2026 - 2029 Integrated Plan

2026- 2027 Intermittent Update

Tehama County

The Behavioral Health Services Act (BHSA) requires counties to submit three-year Integrated Plans (IPs) for Behavioral Health Services and Outcomes. For related policy information, refer to 3.A. Purpose of the Integrated Plan.

General Information

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to 3.A. General Information.

General Information

County, City, Joint Powers, or Joint Submission

County

Entity Name

Tehama County

Behavioral Health Agency Name

Tehama County Health Services Agency

Behavioral Health Agency Mailing Address

P. O. Box 400 Red Bluff, CA 96080

County Behavioral Health System Overview

Please provide the city/county behavioral health system (inclusive of mental health and substance use disorder) information listed throughout this section. The purpose of this section is to provide a high-level overview of the city/county behavioral health system's populations served, technological infrastructure, and services provided. This information is intended to support city/county planning and transparency for stakeholders. The Department of Health Care Services recognizes that some information provided in this section is subject to change over the course of the Integrated Plan (IP) period. All data should be based on FY preceding the year plan development begins (i.e., for 2026-2029 IP, data from FY 2023-2024 should be used).

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to 3.E.2 General Requirements.

Populations Served by County Behavioral Health System

Includes individuals that have been served through the county Medi-Cal Behavioral Health Delivery System and individuals served through other county behavioral health programs. Population-level behavioral health measures, including for untreated behavioral health conditions, are covered in the Statewide Behavioral Health Goals section and County Population-Level Behavioral Health Measure Workbook.For related policy information, refer to 2.B.3 Eligible Populations and 3.A.2 Contents of the Integrated Plan.

Children and Youth

In the table below, please report the number of children and youth (under 21) served by the county behavioral health system who meet the criteria listed in each row. **Counts may be duplicated as individuals may be included in more than one category**.

Criteria	Number of Children and Youth Under Age 21
Received Medi-Cal Specialty Mental Health Services	180

Criteria	Number of Children and Youth Under Age 21
(SMHS)	
Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service	0
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	32
Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC-ODS plan	<11*
Accessed the Early Psychosis Intervention Plus Program, pursuant to Welfare and Institutions Code Part 3.4 (commencing with section 5835), Coordinated Specialty Care, or other similar evidence-based practices and community-defined evidence practices for early psychosis and mood disorder detection and intervention programs	0
Were chronically homeless or experiencing homelessness or at risk of homelessness	0
Were in the juvenile justice system	<11*
Have reentered the community from a youth correctional facility	0
Were served by the Mental Health Plan and had an open child welfare case	0

Criteria	Number of Children and Youth Under Age 21
Were served by the DMC County or DMC-ODS plan and had an open child welfare case	0
Have received acute psychiatric care	55

Adults and Older Adults

In the table below, please report the number of adults and older adults (21 and older) served by the county behavioral health system who meet the criteria listed in each row. **Counts may be duplicated as individuals may be included in more than one category**.

Criteria	Number of Adults and Older Adults
Were dual-eligible Medicare and Medicaid members	241
Received Medi-Cal SMHS	771
Received DMC or DMC-ODS services	299
Received MH and SUD services from the MHP and DMC county or DMC-ODS plan	94
Were chronically homeless, or experiencing homelessness, or at risk of homelessness	0
Experienced unsheltered homelessness	0
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	0

Criteria	Number of Adults and Older Adults
Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing	0
Were in the justice system (on parole or probation and not currently incarcerated)	0
Were incarcerated (including state prison and jail)	19
Reentered the community from state prison or county jail	0
Received acute psychiatric services	135

Input the number of persons in designated and approved facilities who were

Admitted or detained for 72-hour evaluation and treatment rate

431

Admitted for 14-day and 30-day periods of intensive treatment

207

Admitted for 180-day post certification intensive treatment

0

Please report the total population enrolled in Department of State Hospital (DSH) Lanterman-Petris-Short (LPS) Act programs

0

Please report the total population enrolled in DSH community solution projects (e.g., community-based restoration and diversion programs)

0

Of the data reported in this section, are there any areas where the county would like to provide additional context for DHCS's understanding?

Yes

Please explain

Multiple data elements entered as zero as this is newly required information that Tehama County will need to implement to have adequate data capture.

Please describe the local data used during the planning process

We used billing information, PIT Count and other state reporting documents to inform data.

If desired, provide documentation on the local data used during the planning process

Local CARE Act Implementation

Identify the specific service components within your 3-year Integrated Plan that will support CARE participants. Explain how the county will ensure these individuals receive priority access and specialized coordination within the broader behavioral health continuum, including housing if appropriate.

Tehama County Behavioral Health will support individuals participating in CARE Court by drawing on a robust set of service components outlined within the county's 3 Year Integrated Plan, ensuring they receive

timely, coordinated, and comprehensive care across the behavioral health continuum. The county will prioritize CARE participants for clinical assessment, psychiatric services, intensive case management, crisis response, and community-based outreach, including co-occurring treatment and field-based engagement for individuals who struggle to access services independently. The Behavioral Health team will provide specialized oversight, working closely with in clinical programs, the courts, housing partners, and community organizations to ensure that each participant's CARE Plan is implemented effectively and updated as needed. Consistent with the county's commitment to recovery-oriented care, CARE participants will receive priority access to Full-Service Partnership–level supports, including housing navigation, benefits assistance, and placement into appropriate shelter, transitional housing, supportive housing, or licensed residential treatment settings when clinically indicated. Peer support services (contracted provider), supported employment, and functional supports further enhance engagement and long-term stability. Through cross-system collaboration, data-driven quality improvement, and dedicated service pathways, Tehama County Behavioral Health will ensure that CARE participants receive integrated, person-centered services that promote safety, clinical stabilization, and sustained community living.

Describe how CARE referral pathways will be integrated into existing referral and service pathways within the county behavioral health system.

Tehama County's CARE referral pathways will be fully integrated into the county's existing behavioral health referral and service systems to ensure that individuals eligible for CARE Court are efficiently identified, connected, and transitioned into appropriate levels of care. CARE referrals—whether initiated by family members, first responders, treatment providers, public agencies, or the court—will be routed through established Behavioral Health access points, including the centralized Access Team and the clinical intake workflow. These access points already manage referrals for outpatient services, crisis care, Full-Service Partnerships, and residential placements, and will incorporate CARE-specific screening criteria to flag individuals who may meet CARE eligibility. Once identified, referrals will be triaged within the standard clinical workflow but assigned priority status, prompting expedited assessment, documentation, and linkage to the CARE Court. The clinical team will collaborate closely with Access staff, crisis teams, and housing navigators to confirm eligibility, develop CARE Plans, and ensure smooth transitions to needed services. Because the CARE referral process is embedded within existing pathways—rather than operating as a separate or siloed track—it leverages the county's well established mechanisms for service

authorization, warm handoffs, multidisciplinary case reviews, and cross-system collaboration. This integration ensures that CARE Court participants move seamlessly through the continuum of care, receive timely and appropriate interventions, and remain connected to the broader behavioral health system as they stabilize and transition toward long-term recovery.

Describe the process for identifying and redirecting individuals who are potentially eligible for CARE to alternative pathways when a formal petition is not required or appropriate. For individuals redirected from CARE, describe how the county will confirm and document successful connection to services.

Tehama County Behavioral Health has established a structured process for identifying and redirecting individuals who appear potentially eligible for CARE but for whom a formal petition is not required or clinically appropriate. When individuals are referred through the Access Team, Mobile Crisis, law enforcement, hospitals, family members, or community partners, clinicians conduct an initial screening to assess CARE Court eligibility, clinical need, functional impairment, and engagement readiness. If the screening indicates that the individual can be served effectively through voluntary services or an existing behavioral health pathway, the county redirects them to the most appropriate level of care, including outpatient treatment, Full-Service Partnership services, co-occurring treatment, crisis stabilization, or housing and case management supports. In these cases, staff provide active linkage—ensuring a warm handoff to the receiving program, immediate scheduling of assessment or intake appointments, and connection to benefits specialists, peer support, or housing navigators as needed. The CARE Court clinical team is notified of all redirected cases to ensure oversight and to confirm that the individual is adequately connected and engaged without requiring a petition. Tehama County documents this linkage by recording referral outcomes, appointment attendance, and accepted services in the electronic health record, and by conducting follow-up contacts to verify successful engagement. If the individual declines or disengages from services, or if their condition worsens, Access and clinical teams reassess eligibility and may reinitiate the CARE screening process. This integrated and documented approach ensures that individuals receive timely, appropriate services while reserving CARE Court petitions for cases where formal court involvement is necessary to achieve stabilization and recovery.

County Behavioral Health Technical Infrastructure

Cities submitting their Integrated Plan independently from their counties do not have to complete this section. For related policy information, refer to 6.C.1 Promoting Access to Care Through Efficient Use of State and County Resources Introduction.

Does the county behavioral health system use an Electronic Health Record (EHR)?

Yes

Please select which of the following EHRs the county uses

- Netsmart

County participates in a Qualified Health Information Organization (QHIO)?

Yes

Please select which QHIO the county participates in

- SacValley MedShare

Application Programming Interface Information

Counties are required to implement Application Programming Interfaces (API) in accordance with Behavioral Health Information Notice (BHIN) 22-068 and federal law.

Please provide the link to the county's API endpoint on the county behavioral health plan's website

https://fhir.netsmartcloud.com/payer/provider-directory/v2/082dbbe3-c044-4b11-857f-da6b2b457ce7

Does the county wish to disclose any implementation challenges or concerns with these requirements?

No

Counties are required to meet admission, discharge, and transfer data sharing requirements as outlined in the attachments to BHINs 23-056, 23-057, and 24-016. Does the county wish to disclose any implementation challenges or concerns with these requirements?

No

County Behavioral Health System Service Delivery Landscape

Cities submitting their Integrated Plan independently from their counties do not have to complete this section. For related policy information, refer to 6.C.1 Promoting Access to Care Through Efficient Use of State and County Resources Introduction.

Substance Abuse and Mental Health Services Administration (SAMHSA) Projects for Assistance in Transition from Homelessness (PATH) Grant

Community Mental Health Services Block Grant (MHBG)

Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG)

Opioid Settlement Funds (OSF)

Will the county behavioral health system have planned expenditures for OSF during the Integrated Plan period?

Yes

Please check all set asides the county behavioral health system participates in under OSF Exhibit E

- Address The Needs of Criminal Justice-Involved Persons
- Address The Needs of Pregnant or Parenting Women and Their Families, Including Babies with Neonatal Abstinence Syndrome
- Connect People Who Need Help to The Help They Need (Connections to Care)
- First Responders
- Leadership, Planning, and Coordination

- Prevent Misuse of Opioids
- Prevent Overdose Deaths and Other Harms (Harm Reduction)
- Prevent Over-Prescribing and Ensure Appropriate Prescribing and Dispensing of Opioids
- Research
- Support People in Treatment and Recovery
- Treat Opioid Use Disorder (OUD)
- Training

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

No

Bronzan-McCorquodale Act

The county behavioral health system is mandated to provide the following community mental health services as described in the Bronzan-McCorquodale Act (BMA).

a. Case Management

b. Comprehensive Evaluation and Assessment

c. Group Services

d. Individual Service Plan

e. Medication Education and Management

f. Pre-crisis and Crisis Services

g. Rehabilitation and Support Services

h. Residential Services

i. Services for Homeless Persons

j. Twenty-four-hour Treatment Services

k. Vocational Rehabilitation

In addition, BMA funds may be used for the specific services identified in the list below. Select all services that are funded with BMA funds:

- Coordinated Specialty Care for First Episode Psychosis (CSC for FEP)

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

No

Public Safety Realignment (2011 Realignment)

The county behavioral health system is required to provide the following services which may be funded under the Public Safety Realignment (2011 Realignment)

a. Drug Courts

b. Medi-Cal Specialty Mental Health Services, including Early Periodic Screening Diagnostic Treatment (EPSDT)

c. Regular and Perinatal Drug Medi-Cal Services

d. Regular and Perinatal DMC Organized Delivery System Services, including EPSDT

e. Regular and Perinatal Non-Drug Medi-Cal Services

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

No

Medi-Cal Specialty Mental Health Services (SMHS)

The county behavioral health system is mandated to provide the following services under SMHS authority (no action required).

a. Adult Residential Treatment Services

b. Crisis Intervention

c. Crisis Residential Treatment Services

d. Crisis Stabilization

e. Day Rehabilitation

f. Day Treatment Intensive

g. Mental Health Services

h. Medication Support Services

i. Mobile Crisis Services

j. Psychiatric Health Facility Services

k. Psychiatric Inpatient Hospital Services

l. Targeted Case Management

m. Functional Family Therapy for individuals under the age of 21

n. High Fidelity Wraparound for individuals under the age of 21

o. Intensive Care Coordination for individuals under the age of 21

p. Intensive Home-based Services for individuals under the age of 21

q. Multisystemic Therapy for individuals under the age of 21

r. Parent-Child Interaction Therapy for individuals under the age of 21

s. Therapeutic Behavioral Services for individuals under the age of 21

t. Therapeutic Foster Care for individuals under the age of 21

u. All Other Medically Necessary SMHS for individuals under the age of 21

Has the county behavioral health system opted to provide the specific Medi-Cal SMHS identified in the list below as of June 30, 2026?

- CSC for FEP

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

No

Drug Medi-Cal (DMC)/Drug Medi-Cal Organized Delivery System (DMC-ODS)

Select which of the following services the county behavioral health system participates in

DMC Program

Drug Medi-Cal Program (DMC)

The county behavioral health system is mandated to provide the following services as a part of the DMC Program (no action required)

a. All Other Medically Necessary Services for individuals under age 21

b. Intensive Outpatient Treatment Services

c. Medications for Addiction Treatment (including medication, counseling services, and behavioral therapy) (MAT)

d. Mobile Crisis Services

e. Narcotic Treatment Program (NTP) Services

f. Outpatient Treatment Services

g. Perinatal Residential Substance Use Disorder (SUD) Treatment for pregnant women and women in the postpartum period

Has the county behavioral health system opted to provide the specific services identified in the list below?

- Enhanced CHW Services
- IPS Supported Employment
- Peer Support Services

Does the county wish to disclose any implementation challenges or concerns with the

requirements under this program?

No

Other Programs and Services

Please list any other programs and services the county behavioral health system provides through other federal grants or other county mental health and SUD programs

Program or service

Care Transitions

Has the county implemented the state-mandated Transition of Care Tool for Medi-Cal Mental Health Services (Adult and Youth)?

Yes

Does the county's Memorandum of Understanding include a description of the system used to transition a member's care between the member's mental health plan and their managed care plan based upon the member's health condition?

Yes

Statewide Behavioral Health Goals

All fields must be completed unless marked as optional. You don't need to finish everything at once-your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to, please see 3.E.6 Statewide behavioral health goals

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Population-Level Behavioral Health Measures

The statewide behavioral health goals and associated population-level behavioral health measures must be used in the county Behavioral Health Services Act (BHSA) planning process and should inform resource planning and implementation of targeted interventions to improve outcomes for the fiscal year(s) being addressed in the IP. For more information on the statewide behavioral health goals, please see the Policy Manual Chapter 2, Section C.

Please review your county's status on each population-level behavioral health measure, including the primary measures and supplemental measures for each of the 14 goals. All measures are publicly available, and counties are able to review their status by accessing the measures via DHCS-provided instructions and the County Population-Level Behavioral Health Measure Workbook.

As part of this review, counties are required to evaluate disparities related to the six priority statewide behavioral health goals. Counties are encouraged to use their existing tools, methods, and systems to support this analysis and may also incorporate local data sources to strengthen their evaluation.

Please note that several Phase 1 measures include demographic stratifications – such as race, sex, age, and spoken language – which are included in the prompts below. Counties may also use local data to conduct additional analyses beyond these demographic categories.

For related policy information, refer to E.6.1 Population-level Behavioral Health Measures.

- Mark page as complete

Priority statewide behavioral health goals for improvement

Counties are required to address the six priority statewide behavioral health goals in this section. Cities should utilize data that corresponds to the county they are located within. As such, the City of Berkeley should use data from Alameda County and Tri-City should use data from Los Angeles County. For related policy information, refer to E.6.2 Primary and Supplemental Measures.

Access to care: Primary measures

Specialty Mental Health Services (SMHS) Penetration Rates for Adults and Children & Youth (DHCS), FY 2023

How does your county status compare to the statewide rate?

For adults/older adults

Below

For children/youth

Below

What disparities did you identify across demographic groups or special populations?

- No Disparities Data Available

Non-Specialty Mental Health Services (NSMHS) Penetration Rates for Adults and Children & Youth (DHCS), FY 2023

How does your county status compare to the statewide rate?

For adults/older adults

Above

For children/youth

Below

What disparities did you identify across demographic groups or special populations?

- No Disparities Data Available

Drug Medi-Cal (DMC) Penetration Rates for Adults and Children & Youth (DHCS), FY 2022 - 2023

How does your county status compare to the statewide rate?

For adults/older adults

Above

For children/youth

Same

What disparities did you identify across demographic groups or special populations?

- No Disparities Data Available

Drug Medi-Cal Organized Delivery System (DMC-ODS) Penetration Rates for Adults and Children & Youth (DHCS), FY 2022 - 2023

How does your county status compare to the statewide rate?

For adults/older adults

Not Applicable

For children/youth

Not Applicable

What disparities did you identify across demographic groups or special populations?

- No Disparities Data Available

Access to care: Supplemental Measures

Initiation of Substance Use Disorder Treatment (IET-INI) (DHCS), FY 2023

How does your county status compare to the statewide rate?

Below

What disparities did you identify across demographic groups or special populations?

- No Disparities Data Available

Access to care: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis

Youth penetration rates in Tehama County remain below the statewide average due to a combination of demographic, geographic, and systems-level factors that influence access and engagement. Tehama County is a largely rural region, and many families face challenges related to limited transportation, long travel distances, and fewer service locations compared to more urbanized counties. These barriers can make it more difficult for youth to consistently access programs and supports.

Adult MHS Demographic Dashboard (AB470) | Behavioral Health Reporting provides TCHSA SMHS Penetration Rates for Adults 21 and Over as follows: 21-32, 33-44, 45-56, 57-68 years of age are all at 3%,

with adults 69+ years of age at 1%. Statewide penetration rates are listed as those aged 21-32, 33-44, 45-56, 57-68 years at 4%, with those 69+ years of age at 1%.

According to Children and Youth MHS Demographic Dashboard (AB470) | Behavioral Health Reporting, TCHSA SMHS Penetration Rates for Children and Youth Under the Age of 21 range from 2% for those aged 6-11, 4% for those 12-17 years, and 2% for those 18-20 years, with Statewide penetration rates of 1% for those 0-2 years, 2% for 3-5 years, 4% for 6-11 year, 7% for 12-17 years, and 4% for 18-20 years of age. Furthermore, the penetration rate for those whose primary written language is Spanish, the TCHSA penetration rate is 2%, with a Statewide penetration rate of 4%.

Children and Youth MHS Demographic Dashboard (AB470) | Behavioral Health Reporting shows that penetration rates of NSMHS for children and youth under the age of 21 to be 20% for those 0-2 years, 9% for those 3-5 years, 7% for those 6-11 years, 12% for those 12-17 years, and 10% for those 18-20 years of age. Statewide penetration rates are shown as: 26% for 0-2 years, 14% for 3-5 years, 10% for 6-11 years, 16% for 12-17 years, and 11% for 18-20 years of age.

Access to care: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may increase your county's level of access to care. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes

Tehama County was below the statewide penetrations rates for children and youth access to SMHS and initiation of substance use disorder treatment.
*Strengthen outreach and engagement efforts that move beyond awareness building to ensure identified individuals are directly connected to SMHS treatment through warm hand-offs and closed-loop referral systems.
*Expand children/youth SMHS in outlying areas of the community, Corning, Los Molinos, Gerber, and

Rancho Tehama to provide access to treatment.
*Expand Assertive Field-Based SUD Services to meet members where they are to provide on-the-spot assessments and immediate linkage to care.
*Utilize partnerships with local non-profits and other CBOs through housing programs to provide access to SMHS and SURS treatment.
*Renewed focus on engagement from homelessness to permanent housing solutions to encourage engagement with SMHS and SURS to increase access to services.

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Please identify the category or categories of funding that the county is using to address the access to care goal

- BHSA Behavioral Health Services and Supports (BHSS)
- BHSA Full Services Partnership (FSP)
- 1991 Realignment
- 2011 Realignment
- State General Fund
- Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS)
- Substance Abuse and Mental Health Services Administration(SAMHSA) Projects for Assistance in Transition from Homelessness(PATH)
- Community Mental Health Block Grant (MHBG)
- Substance Use Block Grant (SUBG)
- BHSA Housing Interventions

Homelessness: Primary measures

People Experiencing Homelessness Point-in-Time Count (Rate per 10,000 people by Continuum of Care Region) (HUD), 2024

How does your county status compare to the PIT Count Rate out of every 10,000 people by

Continuum of Care region?

Above

What disparities did you identify across demographic groups or special populations?

- No Disparities Data Available

Homeless Student Enrollment by Dwelling Type, California Department of Education (CDE), 2023 - 2024

How does your county status compare to the statewide rate?

Above

What disparities did you identify across demographic groups or special populations?

- No Disparities Data Available

Homelessness: Supplemental Measures

PIT Count Rate of People Experience Homelessness with Severe Mental Illness, (Rate per 10,000 people by Continuum of Care Region) (HUD), 2024

How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region?

Below

What disparities did you identify across demographic groups or special populations?

- No Disparities Data Available

PIT Count Rate of People Experience Homelessness with Chronic Substance Abuse, (Rate per

10,000 people by Continuum of Care Region) (HUD), 2024

How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region?

Below

What disparities did you identify across demographic groups or special populations?

- No Disparities Data Available

People Experiencing Homelessness Who Accessed Services from a Continuum of Care (CoC) Rate (BCSH), 2023 (This measure will increase as people access services.)

How does your local CoC's rate compare to the average rate across all CoCs?

Above

What disparities did you identify across demographic groups or special populations?

- No Disparities Data Available

Homelessness: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis

Tehama County is a geographically large and predominantly rural region. Many individuals experiencing homelessness reside in remote or dispersed locations, making consistent outreach, engagement, and transportation to services more challenging. Limited public transit options and long travel distances create significant access barriers for people who are highly mobile or unsheltered.

Utilizing CoC Homeless Populations and Subpopulations Reports - HUD Exchange for Tehama County and

the State of California, and comparing the “Total Homeless Persons” to the reported 2024 population of each; Tehama County had a rate of 0.0050, compared to the state rate of 0.0047 for People Experiencing Homelessness Point-in-Time Count.

For Homeless Student Enrollment by Dwelling Type, California Department of Education (CDE), 2023-2024, Homeless Enrollment by Dwelling Type - Tehama County (CA Dept of Education) shows that Tehama County had 747 Homeless Student Enrollment, with 81.0% Temporarily Doubled-Up, 5.8% in Temporary Shelters, 6.8% in Hotels/Motels, and 6.4% Temporarily Unsheltered, with a total rate of 0.065 of enrolled students experiencing homelessness. Statewide numbers demonstrated 286,853 Homeless Student Enrollment, with 83.3% Temporarily Doubled-Up, 7.0% in Temporary Shelters, 5.9% in Hotels/Motels, and 3.9% Temporarily Unsheltered, with a total rate of 0.048 of enrolled students experiencing homelessness.

Homelessness: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county’s level of homelessness in the population experiencing severe mental illness, severe SUD, or co-occurring conditions. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

Homelessness rates in Tehama County remain below the statewide average due to a combination of demographic, geographic, and systems-level factors that influence access and engagement. Tehama County is a largely rural region, and many families face challenges related to limited transportation, long travel distances, and fewer service locations compared to more urbanized counties. These barriers can make it more difficult for youth to consistently access programs and supports.
Tehama County Health Services Agency (the county) is partnering with two housing developers to construct new residential facilities for No Place Like Home (NPLH) and Homekey+ residents. Construction is projected to be completed in early to mid-Calendar Year 2027 and will have a combined total of 84 new housing units, with 34 Permanent Supportive Housing units for NPLH and Project Homekey+ residents.

Additionally, the county has partnered with The Poor and the Homeless (P.A.T.H.), a non-profit entity providing services for individuals experiencing homelessness to utilize Behavioral Health Bridge Housing (BHBH) funds for the provision of housing through the placement of Tiny Homes, a modular, and a Transitional Housing facility. These resources will provide housing solutions for 25 individuals as well as Supportive Services and Case Management to ensure transitioning to permanent housing. Also, PLHA funds will be utilized by the P.A.T.H. Navigation Center in assisting participants to obtain and retain housing through supportive services that include case management, resource navigation, and connections to medical, mental health, and substance use recovery services.
The county and P.A.T.H. will be cooperating in the delivery of the Medi-Cal member benefit of Transitional Rent with our Managed Care Provider (MCP) Partnership Health Plan of California.

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Please identify the category or categories of funding that the county is using to address the homelessness goal

- BHSA FSP
- BHSA Housing Interventions
- SAMHSA PATH
- MHBG
- Other
- Federal Financial Participation (SMHS, DMC/DMC-ODS)
- BHSA BHSS
- 1991 Realignment
- 2011 Realignment
- SUBG

Please describe other

Behavioral Health Bridge Housing (BHBH)

Institutionalization

Per 42 CFR 435.1010, an institution is "an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor." Institutional settings are intended for individuals with conditions including, but not limited to, behavioral health conditions.

Care provided in inpatient and residential (i.e., institutional) settings can be clinically appropriate and is part of the care continuum. Here, institutionalization refers to individuals residing in these settings longer than clinically appropriate. Therefore, the goal is not to reduce stays in institutional settings to zero. The focus of this goal is on reducing stays in institutional settings that provide a Level of Care that is not – or is no longer – the least restrictive environment. (no action)

Institutionalization: Primary Measures

Inpatient administrative days (DHCS) rate, FY 2023

How does your county status compare to the statewide rate/average?

For adults/older adults

Not Applicable

For children/youth

Not Applicable

What disparities did you identify across demographic groups or special populations?

- No Disparities Data Available

Institutionalization: Supplemental Measures

Involuntary Detention Rates, FY 2021 - 2022

How does your county status compare to the statewide rate/average?

14-day involuntary detention rates per 10,000

Not Applicable

30-day involuntary detention rates per 10,000

Not Applicable

180-day post-certification involuntary detention rates per 10,000

Not Applicable

What disparities did you identify across demographic groups or special populations?

- No Disparities Data Available

Conservatorships, FY 2021 - 2022

How does your county status compare to the statewide rate/average?

Temporary Conservatorships

Not Applicable

Permanent Conservatorships

Not Applicable

What disparities did you identify across demographic groups or special populations?

- No Disparities Data Available

SMHS Crisis Service Utilization (Crisis Intervention, Crisis Residential Treatment Services, and Crisis Stabilization) (DHCS), FY 2023
Increasing access to crisis services may reduce or prevent unnecessary admissions to institutional facilities

How does your county status compare to the statewide rate/average?

Crisis Intervention

For adults/older adults

Below

For children/youth

Below

Crisis Residential Treatment Services

For adults/older adults

Not Applicable

For children/youth

Not Applicable

Crisis Stabilization

For adults/older adults

Not Applicable

For children/youth

Not Applicable

What disparities did you identify across demographic groups or special populations?

- No Disparities Data Available

Institutionalization: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis

Tehama County faces significant disparities in both access to and utilization of crisis services across youth and adult populations. These disparities are driven by a combination of geographic, resource, and system-level limitations that restrict timely behavioral health intervention during periods of acute crisis.

SMHS Crisis Service Utilization (Crisis Intervention) as per Adult MHS Demographic Dashboard (AB470) | Behavioral Health Reporting Total Units/Minutes/Hours/Days Per Beneficiary is annotated as 167.65/33 female and 164.52/22 male participants, and a total utilization of 5.5k for female and 3.6k for male individuals. Statewide rates are reported as 225.76/21,500 female and 244.1/25,100 male participants, with a total utilization of 4.9million for female and 6.1million for male individuals.

Per the Children and Youth MHS Demographic Dashboard (AB470) | Behavioral Health Reporting dashboard, it shows that Total Units/Minutes/Hours/Days Per Beneficiary is annotated as 218.66/17 female and 326.08/12 male participants. Statewide rates are reported as 288.32/14,400 female and 275.61/9,200 male participants.

Institutionalization: Cross-Measure Questions

What additional local data do you have on the current status of institutionalization in your county? (Example: utilization of Mental Health Rehabilitation Center or Skilled Nursing Facility-Special Treatment Programs)

None at this time.

File Upload

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's rate of institutionalization. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., enhancing crisis response services targeting a sub-population in which data demonstrates they have poorer outcomes)

Tehama County faces significant disparities in both access to and utilization of crisis services across youth and adult populations. These disparities are driven by a combination of geographic, resource, and system-level limitations that restrict timely behavioral health intervention during periods of acute crisis. Tehama County has a clinician designated to a caseload that focuses on reducing or transitioning member to a lower level of care by incorporating case management and rehabilitation services to support independence with our members. The county has a Mobile Crisis Team that responds to any call for assistance with immediate mental health concerns and is capable of meeting the individuals where they are most comfortable. The goal of the Mobile Crisis Team is to maintain and stabilize individuals in the community and avoid unnecessary hospitalizations. Future plans include expansion of Enhanced Care Management to stabilize individuals in lower levels of care and reduce institutionalizations.

File Upload

Please identify the category or categories of funding that the county is using to address the

institutionalization goal

- BHSA BHSS
- BHSA FSP
- 1991 Realignment
- 2011 Realignment
- BHSA Housing Interventions
- Federal Financial Participation (SMHS, DMC/DMC-ODS)
- SAMHSA PATH
- MHBG
- SUBG

Justice-Involvement: Primary Measures

Arrests: Adult and Juvenile Rates (Department of Justice), Statistical Year 2023

How does your county status compare to the statewide rate/average?

For adults/older adults

Above

For juveniles

Above

What disparities did you identify across demographic groups or special populations?

- No Disparities Data Available

Justice-Involvement: Supplemental Measures

Adult Recidivism Conviction Rate (California Department of Corrections and Rehabilitation

(CDCR)), FY 2019 - 2020

How does your county status compare to the statewide rate/average?

Above

What disparities did you identify across demographic groups or special populations?

- No Disparities Data Available

Incompetent to Stand Trial (IST) Count (Department of State Hospitals(DSH)), FY 2023
Note: The IST count includes all programs funded by DSH, including, state hospital, Jail Based Competency Treatment (JBCT), waitlist, community inpatient facilities, conditional release, community-based restoration and diversion programs. However, this count excludes county-funded programs. As such, individuals with Felony IST designations who are court-ordered to county-funded programs are not included in this count.

How does your county status compare to the statewide rate/average?

Above

What disparities did you identify across demographic groups or special populations?

- No Disparities Data Available

Justice-Involvement: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis

Tehama County experiences justice-involved rates for both youth and adults that exceed state standards, reflecting a combination of structural, geographic, and service-system challenges. These disparities are influenced by limited local behavioral health resources, socioeconomic pressures, and gaps in

early-intervention supports that otherwise help prevent entry into the justice system.

According to State of California Department of Justice - OpenJustice the total Arrests for Adults in Tehama County for 2023 is listed as 2,485, with an arrest rate of 0.039, with the Statewide total being reported as 986,765 with an arrest rate of 0.025.

Additionally, the State of California Department of Justice - OpenJustice lists Juvenile arrests in Tehama County for 2023 as 246 with an arrest rate of 0.016 (utilized Easy Access to Juvenile Populations: Population Profiles to determine rate based on juvenile population). The Statewide total was reported as 47,461 with an arrest rate of 0.006.

Adult Recidivism Conviction Rate as reported according to Microsoft Power BI for Tehama County is: conviction rate – 43.0%, number released – 149, and number convicted – 64; with the Statewide numbers as follows: conviction rate – 39.1%, number released – 34,215, and number convicted – 13,395.

Incompetent to Stand Trial (IST) Count can be found at FY 23-23_Reconciled Data Report & Memo.pdf and Tehama County is shown to have 26 "Initial Count – FY2023-24 IST Determinations", which would be a population-based rate of 0.0004. Statewide numbers are displayed as 5,562 with a population-based rate of 0.0001.

Justice-Involvement: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of justice-involvement for those living with significant behavioral health needs. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

Tehama County experiences justice-involved rates for both youth and adults that exceed state standards, reflecting a combination of structural, geographic, and service-system challenges. These disparities are influenced by limited local behavioral health resources, socioeconomic pressures, and gaps in early-intervention supports that otherwise help prevent entry into the justice system.
Tehama County has the following programs below that we will continue to develop and strengthen to help reduce Justice Involvement for both youth and adults.
Behavioral Health Court
Drug Court
JDF Justice-Involved Youth
Project Restore
Prop 36
AB 109
Adolescent Outpatient Treatment Program

File Upload

Please identify the category or categories of funding that the county is nusing to address the justice-involvement goal

- Federal Financial Participation (SMHS, DMC/DMC-ODS)
- Other
- BHSA FSP
- BHSA BHSS
- BHSA Housing Interventions
- 1991 Realignment
- 2011 Realignment
- SAMHSA PATH
- MHBG
- SUBG

Please describe other

Prop 47, Prop 36, AB 109, Opioid Settlement Funds

Removal Of Children from Home: Primary Measures

Children in Foster Care (Child Welfare Indicators Project (CWIP)), as of January 2025

How does your county status compare to the statewide rate?

Above

What disparities did you identify across demographic groups or special populations?

- No Disparities Data Available

Removal Of Children from Home: Supplemental Measures

Open Child Welfare Cases SMHS Penetration Rates (DHCS), 2022

How does your county status compare to the statewide rate?

Below

What disparities did you identify across demographic groups or special populations?

- No Disparities Data Available

Child Maltreatment Substantiations (CWIP), 2022

How does your county status compare to the statewide rate?

Above

What disparities did you identify across demographic groups or special populations?

- No Disparities Data Available

Removal Of Children from Home: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis

The Tehama County 2025 PIT Count does not identify population groups affected on an individual basis with regards to the removal of children from home disparity and is the sole-source of information utilized for this measure as annotated in the County Population Behavioral Health Measure Workbook.

Children in Foster Care is reported at Point in Time/In Care Report California Child Welfare Indicators Project (CCWIP), and for Tehama County it shows 123 individuals, with a population-based rate of 0.002, and Statewide there were 38,649 individuals, with a population-based rate of 0.0009.

Open Child Welfare Cases SMHS Penetration Rates can be found at Children And Youth With An Open Child Welfare Case SMHS Performance Dashboard | Behavioral Health Reporting, with Tehama County reported as having a rate of 27.64%, with Statewide rates being 42.96%.

Child Maltreatment Substantiations as reported on Child Maltreatment Substantiation Rates Report California Child Welfare Indicators Project (CCWIP) for Tehama County shows a rate of 11.5 per 1,000 and a Statewide rate of 6.2 per 1,000.

Removal Of Children from Home: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may increase your county's level of access to care. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes

"Open Child Welfare Case SMHS Penetration Rates" is the sole measure for Tehama County that is below

the statewide average or median. The number of open cases below the statewide measure, and the number of children in foster care measure exceeding the statewide average and median indicates that the identified minors are being assisted by qualified caregivers. TCHSA is currently working with a contracted SMHS provider to deliver High Fidelity Wraparound (HFW) services to those individuals within our community who meet the criteria for this Evidence Based Practice.

File Upload

Please identify the category or categories of funding that the county is nusing to address the removal of children from home goal

- BHSA BHSS
- BHSA FSP
- BHSA Housing Interventions
- 1991 Realignment
- 2011 Realignment
- Federal Financial Participation (SMHS, DMC/DMC-ODS)
- SAMHSA PATH
- MHBG
- SUBG

Untreated Behavioral Health Conditions: Primary Measures

Follow-Up After Emergency Department Visits for Substance Use (FUA-30), 2022

How does your county status compare to the statewide rate/average?

For the full population measured

Below

What disparities did you identify across demographic groups or special populations?

- No Disparities Data Available

Follow-Up After Emergency Department Visits for Mental Illness (FUM-30), 2022

How does your county status compare to the statewide rate/average?

For the full population measured

Below

What disparities did you identify across demographic groups or special populations?

- No Disparities Data Available

Untreated Behavioral Health Conditions: Supplemental Measures

Adults that needed help for emotional/mental health problems or use of alcohol/drugs who had no visits for mental/drug/alcohol issues in past year(CHIS), 2023

How does your county status compare to the statewide rate?

For the full population measured

Below

What disparities did you identify across demographic groups or special populations?

- No Disparities Data Available

Untreated Behavioral Health Conditions: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that

supported your analysis

"Follow-Up After Emergency Department Visit for Substance Use / Mental Illness" do not take into account the Outreach and Engagement efforts of Behavioral Health Substance Use Recovery staff and the methods employed to assists our members with their recovery journey.
"Adults that Needed Help for Emotional/Mental Health Problems or Use of Alcohol/Drugs who had No Visits for Mental/Drug/Alcohol Issues in Past Year" is below the Statewide Rate due to our Behavioral Health Outreach EI measures and stigma reduction which include:
*Continuing to strengthen outreach and engagement efforts that move beyond awareness building to ensure identified individuals are directly connected to SMHS treatment through warm hand-offs and closed-loop referral systems.
*Expanding children/youth SMHS in outlying areas of the community, Corning, Los Molinos, Gerber, and Rancho Tehama to provide access to treatment.
*Expanding Assertive Field-Based SUD Services to meet members where they are to provide on-the-spot assessments and immediate linkage to care.
*Utilizing partnerships with local non-profits and other CBOs through housing programs to provide access to SMHS and SURS treatment.
*Having a renewed focus on engagement from homelessness to permanent housing solutions to encourage engagement with SMHS and SURS to increase access to services.

Follow-up after Emergency Department Visit for Substance Use as reported at Medi-Cal-Managed-Care-Technical-Report-Volume-4.xlsx for Tehama County is grouped into Region 1 with 6 other counties and is split between Anthem Blue Cross Partnership Plan and California Health & Wellness Plan; demonstrating an FUA-30Day rate of 34.23% and 33.93%, both of which are reported to be better than the DHCS-established high performance level of 32.38%.

Follow-Up After Emergency Department Visit for Mental Illness as reported at Medi-Cal-Managed-Care-Technical-Report-Volume-4.xlsx for Tehama County is grouped into Region 1 with 6 other counties and is split between Anthem Blue Cross Partnership Plan and California Health & Wellness Plan; demonstrating an FUM-30Day rate of 59.71% and 51.28% which places Anthem’s rate above the minimum performance level of 54.51% and the latter below the MPL.

Untreated Behavioral Health Conditions: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of untreated behavioral health conditions. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

"Follow-Up After Emergency Department Visit for Substance Use / Mental Illness" do not take into account the Outreach and Engagement efforts of Behavioral Health Substance Use Recovery staff and the methods employed to assists our members with their recovery journey.
"Adults that Needed Help for Emotional/Mental Health Problems or Use of Alcohol/Drugs who had No Visits for Mental/Drug/Alcohol Issues in Past Year" is below the Statewide Rate due to our Behavioral Health Outreach EI measures and stigma reduction which include:
*Continuing to strengthen outreach and engagement efforts that move beyond awareness building to ensure identified individuals are directly connected to SMHS treatment through warm hand-offs and closed-loop referral systems.
*Expanding children/youth SMHS in outlying areas of the community, Corning, Los Molinos, Gerber, and Rancho Tehama to provide access to treatment.
*Expanding Assertive Field-Based SUD Services to meet members where they are to provide on-the-spot assessments and immediate linkage to care.
*Utilizing partnerships with local non-profits and other CBOs through housing programs to provide access to SMHS and SURS treatment.
*Having a renewed focus on engagement from homelessness to permanent housing solutions to encourage engagement with SMHS and SURS to increase access to services.

File Upload

Please identify the category or categories of funding that the county is using to address the

untreated behavioral health conditions goal

- BHSA BHSS
- BHSA FSP
- BHSA Housing Interventions
- 1991 Realignment
- 2011 Realignment
- Federal Financial Participation (SMHS, DMC/DMC-ODS)
- SAMHSA PATH
- MHBG
- SUBG

Additional statewide behavioral health goals for improvement

Please review your county's status on the remaining eight statewide behavioral health goals using the primary measure(s) to compare your county to the statewide status and review the supplemental measure(s) for additional insights in the County Performance Workbook. These measures should inform the overall strategy and where relevant, be incorporated into the planning around the six priority goals.

In the next section, the county will select AT LEAST one goal from below for which your county is performing below the statewide rate/average on the primary measure(s) to improve on as a priority for the county.

For related policy information, refer to E.6.2 Primary and Supplemental Measures.

Care Experience: Primary Measures

Perception of Cultural Appropriateness/Quality Domain Score (Consumer Perception Survey (CPS)), 2024

How does your county status compare to the statewide rate/average?

For adults/older adults

Above

For children/youth

Above

Quality Domain Score (Treatment Perception Survey (TPS)), 2024

How does your county status compare to the statewide rate/average?

For adults/older adults

Above

For children/youth

Above

Engagement In School: Primary Measures

Twelfth Graders who Graduated High School on Time (Kids Count), 2022

How does your county status compare to the statewide rate/average?

Above

Engagement In School: Supplemental Measures

Meaningful Participation at School (California Health Kids Survey (CHKS)), 2023

How does your county status compare to the statewide rate/average?

Below

Student Chronic Absenteeism Rate (Data Quest), 2022

How does your county status compare to the statewide rate/average?

Below

Engagement In Work: Primary Measures

Unemployment Rate (California Employment Development Department (CA EDD)), 2023

How does your county status compare to the statewide rate/average?

Above

Engagement In Work: Supplemental Measures

Unable to Work Due to Mental Problems (California Health Interview Survey (CHIS)), 2023

How does your county status compare to the statewide rate/average?

Above

Overdoses: Primary Measures

All Drug-Related Overdose Deaths (California Department of Public Health (CDPH)), 2022

How does your county status compare to the statewide rate/average?

For the full population measured

Above

For adults/older adults

Above

For children/youth

Below

Overdoses: Supplemental Measures

All-Drug Related Overdose Emergency Department Visits (CDPH), 2022

How does your county status compare to the statewide rate/average?

For the full population measured

Above

For adults/older adults

Above

For children/youth

Above

Prevention And Treatment of Co-Occurring Physical Health Conditions: Primary Measures

Adults' Access to Preventive/Ambulatory Health Service & Child and Adolescent Well-Care Visits (DHCS), 2022

How does your county status compare to the statewide rate/average?

For adults (specific to Adults' Access to Preventive/Ambulatory Health Service)

Above

For children/youth (specific to Child and Adolescent Well-Care Visits)

Below

Prevention And Treatment of Co-Occurring Physical Health Conditions: Supplemental Measures

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications & Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing (DHCS), 2022

How does your county status compare to the statewide rate/average?

For adults/older adults (specific to Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications)

Below

For children/youth (specific to Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing)

Below

Quality Of Life: Primary Measures

Perception of Functioning Domain Score (CPS), 2024

How does your county status compare to the statewide rate/average?

For the full population measured

Below

For adults/older adults

Above

For children/youth

Below

Quality Of Life: Supplemental Measures

Poor Mental Health Days Reported (Behavioral Risk Factor Surveillance System (BRFSS)), 2024

How does your county status compare to the statewide rate/average?

For the full population measured

Above

Social Connection: Primary Measures

Perception of Social Connectedness Domain Score (CPS), 2024

How does your county status compare to the statewide rate/average?

For the full population measured

Above

For adults/older adults

Above

For children/youth

Below

Social Connection: Supplemental Measures

Caring Adult Relationships at School (CHKS), 2023

How does your county status compare to the statewide rate/average?

Below

Suicides: Primary Measures

Suicide Deaths, 2022

How does your county status compare to the statewide rate/average?

For the full population measured

Above

Suicides: Supplemental Measures

Non-Fatal Emergency Department Visits Due to Self-Harm, 2022

How does your county status compare to the statewide rate/average?

For the full population measured

Above

For adults/older adults

Above

For children/youth

Below

County-selected statewide population behavioral health goals

For related policy information, refer to 3.E.6 Statewide Behavioral Health Goals.

Based on your county's performance or inequities identified, select at least one additional goal to improve on as a priority for the county for which your county is performing below the statewide rate/average on the primary measure(s). For each county-selected goal, provide the information requested below.

- Suicides

Suicides

Please describe why this goal was selected

Tehama County's rates of completed suicide are 27.8 per 100,000. Placing us well above the average for the statewide measures.

What disparities did you identify across demographic groups or priority populations among the Additional Statewide Behavioral Health Goals? For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis

No data to graph. Rates not available.

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may improve your county's level of

Suicides and refer to any data that was used to make this decision (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

Tehama County's rates of completed suicide are 27.8 per 100,000. Placing us well above the average for the statewide measures. TCHSA will strengthen our MCT HMA Policy Academy Outreach Stigma reduction and engaging in a media campaign to highlight the accessibility of services to those in crisis.

Please identify the category or categories of funding that the county is using to address this goal

- BHSA BHSS
- BHSA FSP
- BHSA Housing Interventions
- 1991 Realignment
- 2011 Realignment
- Federal Financial Participation (SMHS, DMC/DMC-ODS)
- SAMHSA PATH
- MHBG
- SUBG

Community Planning Process

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 3.B Community Planning Process.

Stakeholder Engagement

For related policy information, refer to 3.B.1 Stakeholder involvement

Please indicate the type of engagement used to obtain input on the planning process

- Focus group discussions
- Meeting(s) with county
- County outreach through townhall meetings
- Survey participation
- Training, education, and outreach related to community planning
- Workgroups and committee meetings

Include date(s) of stakeholder engagement for each type of engagement

Type of engagement

Survey participation

Date

12/4/2025

Type of engagement

Focus group discussions

Date

1/6/2026

Type of engagement

Workgroups and committee meetings

Date

1/8/2026

Type of engagement

Training, education, and outreach related to community planning

Date

1/8/2026

Type of engagement

Training, education, and outreach related to community planning

Date

1/13/2026

Type of engagement

Meeting(s) with county

Date

1/15/2026

Type of engagement

Training, education, and outreach related to community planning

Date

1/15/2026

Type of engagement

County outreach through townhall meetings

Date

1/20/2026

Type of engagement

Workgroups and committee meetings

Date

1/21/2026

Type of engagement

County outreach through townhall meetings

Date

1/22/2026

Type of engagement

Training, education, and outreach related to community planning

Date

1/27/2026

Type of engagement

Training, education, and outreach related to community planning

Date

3/27/2026

Type of engagement

Workgroups and committee meetings

Date

2/18/2026

Type of engagement

Training, education, and outreach related to community planning

Date

10/17/2025

Please list specific stakeholder organizations that were engaged in the planning process. Please do not include specific names of individuals

Community Members, Sunrise Rotary, Tehama County (TC) Police Activities League, TC Continuum of Care, Northern Valley Catholic Social Service, TC Health Services Agency Certified Peer Providers, Rolling Hills Clinic, Empower Tehama, TC Dept of Social Services, Northern California Child Development Inc., Greenville Rancheria, Dignity Health, The Poor and the Homeless (P.A.T.H.), All Weathers Pumps, Corning Health Care District, TC Health Services Agency, TC Department of Education, Veteran's Hall, Red Bluff High School,

Restpadd Health, TC Library, Northern Valley Services, Red Bluff Health Care, Northern Valley Indian Health, Paskenta Band of Nomlaki Indians, TC Health Care Coalition, TC Public Health Advisory Board, TC Behavioral Health Advisory Board, TC Sheriff's Office, Sierra-Sacramento Valley EMS Agency, Saint Elizabeth Hospital, TC Veteran Services

What are the five most populous cities in counties with a population greater than 200,000 (Cities submitting IP independently are not required to collaborate with other cities) (Population and Housing Estimates for Cities, Counties, and the State)

	City name
1	
2	
3	
4	
5	

Were you able to engage all required stakeholders/groups in the planning process?

Yes

Please describe and provide documentation (such as meeting minutes) to support how diverse stakeholder viewpoints were incorporated into the development of the Integrated Plan, including any community-identified strengths, needs, and priorities

TCHSA engaged in multiple avenues to request input from the community as noted above and demonstrated in the below documents.

Upload File

Local Health Jurisdiction (LHJ)

Cities submitting their Integrated Plan independently from their counties do not have to complete this section. For related policy information, refer to B.2 Considerations of Other Local Program Planning Processes.

Did the county work with its LHJ on the development of the LHJ's recent Community Health Assessment (CHA) and/or Community Health Improvement Plan (CHIP)? Additional information regarding engagement requirements with other local program planning processes can be found in Policy Manual Chapter 3, Section B.2.3.

Yes

Please describe how the county engaged with LHJs, along with Medi-Cal managed care plans (MCPs), across these three areas in developing the CHA and/or CHIP: collaboration, data-sharing, and stakeholder activities

Behavioral Health contributed to the focus groups throughout the CHA and CHIP process.

Did the county utilize the County-LHJ-MCP Collaboration Tool provided via technical assistance?

No

Collaboration

Please select how the county collaborated with the LHJ

- Attended key CHA and CHIP meetings as requested.
- Served on CHA and CHIP governance structures and/or subcommittees as requested.

Data-Sharing

Data-Sharing to Support the CHA/CHIP

Select Statewide Behavioral Health Goals that were identified for data-sharing to support behavioral health-related focus areas of the CHA and CHIP

- Access to Care
- Engagement in School
- Engagement in Work
- Untreated Behavioral Health (BH) Conditions (e.g., substance use disorder, depression, maternal and child behavioral disorders, other adult mental health conditions)

Was data shared?

Yes

Data-Sharing from MCPS and LHJs to Support IP development

Select Statewide Behavioral Health Goals that were identified for data-sharing to inform IP development

- Access to Care
- Engagement in School
- Engagement in Work
- Untreated Behavioral Health (BH) Conditions (e.g., substance use disorder, depression, maternal and child behavioral disorders, other adult mental health conditions)

Was data shared?

No

Stakeholder Activities

Select which stakeholder activities the county has coordinated for IP development with the LHJ engagement on the CHA/CHIP. Please note that although counties must coordinate stakeholder activities with LHJ CHA/CHIP processes (where feasible), the options below are for illustrative

purposes only and are not required forms of stakeholder activity coordination (e.g., counties do not need to conduct each of these activities)

- Collaborated with LHJ to identify shared stakeholders that are key for both the IP and CHA/CHIP process.
- Collaborated on joint surveys, focus groups, and/or interviews that can be used to inform both the IP and CHA/CHIP.
- Co-hosted community sessions, listening tours, and/or other community events that can be used to strengthen stakeholder engagement for both the IP and CHA/CHIP.
- Coordinated messaging and stakeholder events calendars (e.g., governance meetings) around IP development and CHA/CHIP engagement.

Most Recent Community Health Assessment (CHA), Community Health Improvement Plan (CHIP) or Strategic Plan

Has the county considered either the LHJ's most recent CHA/CHIP or strategic plan in the development of its IP? Additional information regarding engagement requirements with other local program planning processes can be found in Policy Manual Chapter 3, Section B.2.3

Yes

Provide a brief description of how the county has considered the LHJ's CHA/CHIP or strategic plan when preparing its IP

In order to develop an aligned IP, we have drawn from the efforts and insights gained from the LHJ's CHA/CHIP processes and final publications to inform our formulation of a thriving community through appropriate assessment, assurance, and policy development, and thereby meeting the needs of the community as a whole.

Medi-Cal Managed Care Plan (MCP) Community Reinvestment

For related policy information, refer to B.2 Considerations of Other Local Program Planning Processes.

Please list the Managed Care Plans (MCP) the county worked with to inform the MCPs' respective

community reinvestment planning and decision-making processes

Partnership Healthplan of California

Which activities in the MCP Community Reinvestment Plan submissions address needs identified through the Behavioral Health Services Act community planning process and collaboration between the county, MCP, and other stakeholders on the county's Integrated Plan?

The challenges faced by Tehama County residents include, but are not limited to, high poverty and unemployment rates, low education completion, and restricted access to healthcare.

Comment Period and Public Hearing

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to B.3 Public Comment and Updates to the Integrated Plan.

Comment Period and Public Hearing

For related policy information, refer to B.3 Public Comment and Updates to the Integrated Plan.

- Confirm that the data is up to date and reflects the correct information for an Intermittent Update

Date the draft Integrated Plan (IP) was released for stakeholder comment

9/25/2026

Date the stakeholder comment period closed

10/26/2026

Date of behavioral health board public hearing on draft IP

10/21/2026

Please provide proof of a public posting with information on the public hearing. Please select the county's preferred submission modality

Link

Please provide the link to the public posting

https://www.tehamacohealthservices.net/news/

If the county uses an existing landing page or other web-based location to publicly post IPs for comment, please provide a link to the landing page

https://www.tehamacohealthservices.net/news/

File Upload

Please select the process by which the draft plan was circulated to stakeholders

- Public posting

Please describe stakeholder input in the table below. Please add each stakeholder group into their own row in the table

Stakeholder group that provided feedback

None at this time

Summarize the substantive revisions recommended this stakeholder during the comment period

None at this time

Please describe any substantive recommendations made by the local behavioral health board that are not included in the final Integrated Plan or update. If no substantive revisions were recommended by stakeholders during the comment period, please input N/A.

Substantive recommendations

None at this time

County Behavioral Health Services Care Continuum

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress.

County Behavioral Health Services Care Continuum

The Behavioral Health Care Continuum is composed of two distinct frameworks for substance use disorder and mental health services. These frameworks are used for counties to demonstrate planned expenditures across key service categories in their service continuum. Questions on the Behavioral Health Care Continuum are in the Integrated Plan Budget Template.

- Mark section as complete

County Provider Monitoring and Oversight

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to 6.C.2 Securing Medi-Cal Payment.

Medi-Cal Quality Improvement Plans

Cities submitting their Integrated Plan independently from their counties do not have to complete this section or Question 1 under All BHSA Provider Locations.

For Specialty Mental Health Services (SMHS) or for integrated SMHS/Drug Medi-Cal Organized Delivery System (DMC-ODS) contracts under Behavioral Health Administrative Integration, please upload a copy of the county's current Quality Improvement Plan (QIP) for State Fiscal Year (SFY) 2026-2027

Does the county operate a standalone DMC-ODS program (i.e., a DMC-ODS program that is not under an integrated SMHS/DMC-ODS contract)?

No

Contracted BHSA Provider Locations

As of the date this report is submitted, please provide the total number of contracted Behavioral Health Services Act (BHSA) provider locations offering non-Housing services for SFY 2025-26. I.e., BHSA-funded locations that are (i) not owned or operated by the county, and (ii) offer BHSA services other than Housing Interventions services. (A provider location should be counted if it offers both Housing Interventions and mental health (MH) or substance use disorder services (SUD); provider location that contracts with the county to provide both mental health and substance use disorder services should be counted separately.)

Services Provided	Number of contracted BHSA provider locations
Mental Health (MH) services only	3
Substance Use Disorder (SUD) services only	0
Both MH and SUD services	0

Among the county's contracted BHSA provider locations, please identify the number of locations that also participate in the county's Medi-Cal Behavioral Health Delivery System (BHDS) (including SMHS and Drug MC/DMC-ODS) for SFY 2025-26

Services Provided	Number of Contracted BHSA Provider Locations
SMHS only	3
DMC/DMC-ODS only	0
Both SMHS and DMC/DMC-ODS systems	0

All BHSA Provider Locations

For related policy information, refer to B.2 Considerations of Other Local Program Planning Processes.

Among the county's BHSA funded SMHS provider locations (county-operated and contracted) that offer services/Levels of Care that may be covered by Medi-Cal MCPs as non-specialty mental health services (NSMHS), what percentage of BHSA funded SMHS providers contract with at least one MCP in the county for the delivery of NSMHS?

Please describe the county's plans to enhance rates of MCP contracting starting July 1, 2027, and over the subsequent two years among the BHSA provider locations that are providing services that can/should be reimbursed by Medi-Cal MCPs

Beginning July 1, 2027, Tehama County Health Services Agency (TCHSA) will implement a multi-year strategy to increase the number of Behavioral Health Safety Net (BHSA) provider locations that establish contracts with Medi-Cal Managed Care Plans (MCPs) for the delivery of Non-Specialty Mental Health Services (NSMHS).

Over the three-year period, TCHSA will:

• Engage all contracted BHSA providers delivering NSMHS to review their current service portfolios and identify services that are reimbursable through MCPs.

• Provide outreach, education, and technical assistance to support providers in understanding MCP requirements, credentialing processes, billing expectations, and contract readiness.

• Facilitate regular coordination meetings with MCPs to improve communication, address contracting barriers, and streamline provider onboarding.

• Encourage and support providers to enter into contracts with at least one MCP, with a goal of increasing MCP participation across all NSMHS provider sites.

• Monitor progress annually and adjust support strategies based on provider needs, MCP feedback, and changes in state policy or Medi-Cal requirements.

Through these efforts, TCHSA aims to expand reimbursement pathways for NSMHS and strengthen the overall sustainability of BHSA provider services within the county.

To maximize resource efficiency, counties must, as of July 1, 2027, require their BHSA providers to (subject to certain exceptions)

a. **Check whether an individual seeking services eligible for BHSA funding is enrolled in Medi-Cal and/or a commercial health plan, and if uninsured, refer the individual for eligibility screening**

b. **Bill the Medi-Cal Behavioral Health Delivery System for covered services for which the provider receives BHSA funding; and**

c. **Make a good faith effort to seek reimbursement from Medi-Cal Managed Care Plans (MCPs) and commercial health plans for covered services for which the provider receives BHSA funding**

Does the county wish to describe implementation challenges or concerns with these requirements?

No

Counties must monitor BHSA-funded providers for compliance with applicable requirements under the Policy Manual, the county's BHSA contract with DHCS, and state law and regulations. Effective SFY 2027-2028, counties must (1) adopt a monitoring schedule that includes periodic site visits and (2) preserve monitoring records, including monitoring reports, county-approved provider Corrective Action Plans (CAPs), and confirmations of CAP resolutions. Counties shall supply these records at any time upon DHCS's request. DHCS encourages counties to adopt the same provider monitoring schedule as under Medi-Cal: annual monitoring with a site visit at least once every three years. For providers that participate in multiple counties' BHSA programs, a county may rely on monitoring performed by another county.

Does the county intend to adopt this recommended monitoring schedule for BHSA-funded providers that:

Also participate in the county's Medi-Cal Behavioral Health Delivery System? (Reminder: Counties may simultaneously monitor for compliance with Medi-Cal and BHSA requirements)

Yes

Do not participate in the county's Medi-Cal Behavioral Health Delivery System?

Yes

Behavioral Health Services Act/Fund Programs

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress.

Behavioral Health Services and Supports (BHSS)

For related policy information, refer to 7.A.1 Behavioral Health Services and Supports Expenditure Guidelines

General

Please select the specific Behavioral Health Services and Supports (BHSS) that are included in your plan

- Adult and Older Adult System of Care (non-FSP)
- Early Intervention Programs (EIP)
- Outreach and Engagement (O&E)
- Workforce, Education and Training (WET)
- Capital Facilities and Technological Needs (CFTN)
- Children's System of Care (non-Full Service Partnership (FSP))

Children's System of Care (Non-Full Service Partnership (FSP)) Program

For each program or service of the county's BHSS funded Children's System of Care (non-FSP) program, provide the following information. If the county provides more than on program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care.

Please select the service types provided under Program

- Mental health services
- Supportive services
- Substance Use Disorder treatment services

Please describe the specific services provided

Tehama County Health Services Agency (TCHSA), Behavioral Health (BH) delivers Children's System of Care through a variety of settings, including but not limited to: Behavioral Health Outpatient Clinics and the field-based deployment of Mental Health Educators, Community Health Workers, Case Resource Specialists, and Peers. Care may include linkage to services/programs (including Substance Use Recovery), peer support, engagement, psychosocial rehabilitation, psychoeducation, system navigation, public health campaigns for suicide prevention, adverse childhood experiences (ACEs) awareness, and financial support and management.
Staffing of Behavioral Health providers is a constant challenge within Tehama County, and TCHSA is dedicated to continuing to employ individuals who are dedicated to assisting our members with their recovery journey.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	575
FY 2027 – 2028	600
FY 2028 – 2029	625

Please describe any data or assumptions your county used to project the number of individuals served through the Children's System of Care

Projections based on reports delineating the number of individuals receiving SMHS and including an expansion to those members of the community with unmet needs.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program

For each program or service type that is part of the county's BHSS funded Adult and Older Adult System of Care (Non-FSP) program, provide the following information. If the county provides more than one program

or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care

Please select the service types provided under Program

- Supportive services
- Mental health services
- Substance Use Disorder (SUD) treatment services

Please describe the specific services provided

Tehama County Health Services Agency (TCHSA), Behavioral Health (BH) delivers Adult/Older Adult Systems of Care through a variety of settings, including but not limited to: Behavioral Health Outpatient Clinics, STANS Wellness & Recovery Center, and the field-based deployment of Mental Health Educators, Community Health Workers, Case Resource Specialists, and Peers. Care may include linkage to services/programs (including Substance Use Recovery), peer support, engagement, psychosocial rehabilitation, psychoeducation, system navigation, public health campaigns for suicide prevention, adverse childhood experiences (ACEs) awareness, and financial support and management.
Staffing of Behavioral Health providers is a constant challenge within Tehama County, and TCHSA is dedicated to continuing to employ individuals who are dedicated to assisting our members with their recovery journey.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	**Projected Number of Individuals Served**
FY 2026 – 2027	775
FY 2027 – 2028	800
FY 2028 – 2029	825

Please describe any data or assumptions the county used to project the number of individuals

served through the Adult and Older Adult System of Care

Projections based on reports delineating the number of individuals receiving SMHS and including an expansion to those members of the community with unmet needs.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3, but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs.

Program or service name

Early Intervention Education

Please select which of the three EI components are included as part of the program or service

- Outreach
- Access and Linkage: Referrals

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs

No

Please describe intended outcomes of the program or service

Tehama County's Early Intervention program is designed to prevent mental illnesses and substance use disorders from becoming severe and disabling while actively reducing disparities in behavioral health access and outcomes across the community. Through robust outreach, education, and skill building initiatives, the county implements a range of evidence based programs—including Mental Health First Aid (MHFA), Youth Mental Health First Aid (YMHFA), Applied Suicide Intervention Skills Training (ASIST), and

Nurturing Families (NF)—that equip community members, families, educators, and first responders to recognize early signs of behavioral health challenges and respond with appropriate support. These programs strengthen the county's early identification network and create multiple, culturally responsive pathways into care, helping individuals receive assistance before symptoms progress to more serious levels. They also play a critical role in reducing stigma, improving understanding of behavioral health conditions, and increasing engagement among populations that have historically faced barriers to services. Throughout trainings, self-care practices are emphasized to promote resilience and wellness among both participants and those they support. By expanding early detection, enhancing community capacity, and fostering equitable access, Tehama County's Early Intervention program lays the foundation for a healthier, more connected community and a more responsive behavioral health continuum.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2

No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	200
FY 2027 – 2028	225
FY 2028 – 2029	250

Please describe any data or assumptions the county used to project the number of individuals served through EI programs

Projected number of individuals served is based on the data from prior years of service, taking into account the probable increase due to consistent outreach and engagement.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3, but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs.

Program or service name

Therapeutic Drumming

Please select which of the three EI components are included as part of the program or service

- Treatment Services and Supports: Other

Please specify "other" type of Treatment Services and Supports

Evidence-Based intervention that reduces stress, boosts immunity, and process emotions.

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs

No

Please describe intended outcomes of the program or service

Reduce stress, boost immune system, mental health support through grounding techniques, provides emotional expression, social connection, cognitive stimulation, trauma release, and community building.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2

No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	1300
FY 2027 – 2028	1400
FY 2028 – 2029	1500

Please describe any data or assumptions the county used to project the number of individuals served through EI programs

The Drumming Circle has about 10-15 participants per week, many of whom return every week (~830), and TCHSA Health Educators reach about 250-500 school-aged participants through outreach programs in the public school system. Projected number of individuals served is based on the previous information and continued outreach and engagement.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3, but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs.

Program or service name

Peer Advocate Program

Please select which of the three EI components are included as part of the program or service

- Outreach
- Access and Linkage: Referrals

- Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs

No

Please describe intended outcomes of the program or service

TCHSA Peer Advocates are individuals who share the experience of living with mental health challenges and are trained to provide recovery-oriented, culturally appropriate services; promoting socialization, self-sufficiency, advocacy, engagement, and supports that are trauma aware.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2

No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	1200
FY 2027 – 2028	1300
FY 2028 – 2029	1400

Please describe any data or assumptions the county used to project the number of individuals served through EI programs

Projected number of individuals served is based on the data from prior years of service, taking into account the probable increase due to consistent outreach and engagement.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3, but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs.

Program or service name

Mobile Crisis Team (MCT)

Please select which of the three EI components are included as part of the program or service

- Outreach
- Access and Linkage: Screenings
- Access and Linkage: Assessments
- Access and Linkage: Referrals
- Treatment Services and Supports: Services to address first episode psychosis (FEP)
- Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
- Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs

Yes

Please select the EBPs and CDEPs that apply

- Mobile Crisis, including use of tools such as the Columbia Suicide Severity Rating Scale or the Stanley-Brown Safety Plan
- Seeking Safety (SS)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Mobile Crisis - Columbia Suicide Severity Rating Scale, Stanley-Brown Safety Plan, and Seeking Safety

Please describe intended outcomes of the program or service

TCHSA Mobile Crisis Team responds to individuals in a behavioral health crisis to assess and provide services and linkages as appropriate to prevent suicide and hospitalization and/or incarceration. Services are provided where the individual is located, whether at a school, home, or in a public space.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2

No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	2000
FY 2027 – 2028	2100
FY 2028 – 2029	2200

Please describe any data or assumptions the county used to project the number of individuals

served through EI programs

Projected number of individuals served is based on the data from prior years of service, taking into account the probable increase in access due to consistent outreach and engagement.

Coordinated Specialty Care for First Episode Psychosis (CSC) program

For related policy information, refer to 7.A.7.5.1 Coordinated Specialty Care for First Episode Psychosis.

Please provide the following information on the county's Coordinated Specialty Care for First Episode Psychosis (CSC) program

CSC program name

Early Psychosis Intervention & Care Coordination (EPICC)

CSC program description

Through early intervention in psychosis and providing immediate access to services, TCHSA aims to decrease hospitalization, institutional placement, incarceration, and morbidity and disability associated with untreated psychosis. Members and families are actively engaged in increasing their knowledge of mental and physical health characteristics while participating in the program. Family involvement is encouraged but not required for members to receive support from the EPICC team, and members can determine which areas of support they wish to engage with. Members and families are provided with an array of services tailored to assist the member while addressing their particular needs and recovery from member-driven goals.

Please review the total estimated number of individuals who may be eligible for CSC (based on the Service Criteria in the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Evidence Based Practice (EBP) Policy Guide and the Policy Manual Chapter 7, Section A.7.5). Please input the estimates provided to the county in the table below.

CSC Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	12
Number of Uninsured Individuals	<11*

CSC Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	4
Number of Teams Needed to Serve Total Eligible Population	1

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for BHSS, please provide the total number of teams and Full-Time Equivalents (FTEs) (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide CSC over this Integrated Plan period, by fiscal year.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	6	7	8
Total Number of Teams	1	1	1

Will the county's CSC program be supplemented with other (non-BHSA) funding source(s)?

No

Outreach and Engagement (O&E) Program

For each program or activity that is part of the county's standalone O&E programs provide the following information. If the county provides more than one program or activity, use the "Add" button. For related policy information, refer to 7.A.3 Outreach and Engagement.

Program or activity name

Community Engagement & Outreach

Please describe the program or activity

Tehama County implements targeted outreach and engagement activities designed to connect unserved and underserved individuals with behavioral health services and support. Health Educators collaborate with community partners, service providers, schools, tribal organizations, and culturally specific groups to identify individuals who may be at increased risk for behavioral health challenges and facilitate access to appropriate resources. Outreach efforts include participation in targeted resource events, small-group educational presentations, referrals from community partners, and engagement in locations frequented by individuals experiencing homelessness, housing instability, social isolation, or other barriers to care.

Health Educators provide culturally and linguistically responsive information and support tailored to the needs of specific populations, including Latino/x communities, tribal communities, LGBTQ+ youth, older adults, and individuals with limited access to transportation or technology. Through relationship-building, individualized engagement, and collaboration with trusted community organizations, these activities help reduce barriers to care, increase awareness of available services, support early identification of behavioral health needs, and facilitate timely connections to treatment and recovery supports. By focusing resources on individuals and groups facing elevated risk or disparities in access, these non-population-based prevention activities strengthen equitable access to behavioral health services and improve outcomes for underserved community members.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	4000
FY 2027 – 2028	4200
FY 2028 – 2029	4500

Please describe any data or assumptions the county used to project the number of individuals served through O&E programs

Projected number of individuals served is based on the data from prior years of service, taking into account the probable increase due to consistent outreach and engagement.

County Workforce, Education, and Training (WET) Program

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).
For each program or activity that is part of the county's overall WET program, provide the following information. If the county provides more than one program or activity type, use the "Add" button. For related policy information, refer to 7.A.4 Workforce Education and Training.

Program or activity name

TCHSA Staff Training & Education

Please select which of the following categories the activity falls under

Continuing Education

Please describe efforts to address disparities in the Behavioral Health workforce. Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9

Tehama County may utilize Behavioral Health Subaccount (BHSS) funds to strengthen and diversify the behavioral health workforce by supporting activities that increase racial, ethnic, and geographic representation and promote the inclusion of individuals with lived experience. These efforts are incorporated across all Workforce, Education & Training (WET) components in recognition of the need for a culturally and linguistically competent workforce capable of meeting the behavioral health needs of residents from all backgrounds. Strategies may include targeted recruitment in rural and frontier areas, partnerships with schools, colleges, and community-based organizations serving diverse populations, and expanded pathways for peers and individuals with lived experience to enter the workforce through training, internships, and career development opportunities. Additionally, TCHSA provides a three-day, POST-certified Crisis Intervention Training (CIT) for law enforcement and first responders throughout the county as well as an added one-day CIT for all county employees. Tehama County is an equal opportunity employer and values diversity within the organization. The county does not discriminate on the basis of race, religion, color, national origin, gender, sexual orientation, age, marital status, veteran status, or disability status, and ensures that individuals with disabilities receive reasonable accommodations during the application, examination, and interview process, in performing essential job functions, and in accessing employment benefits. To request an accommodation, applicants may contact the Personnel Office at tehamahr@co.tehama.ca.us or 530 527 4183. Through the combined use of BHSS funding and inclusive hiring practices, Tehama County aims to build a behavioral health workforce that reflects the community it serves, reduces care disparities, and enhances the effectiveness and cultural responsiveness of services across the behavioral health system.

Capital Facilities and Technological Needs (CFTN) Program

For each project that is part of the county's CFTN project, provide the following information. If the county provides more than one project, use the "Add" button. Additional information on CFTN policies can be found in Policy Manual Chapter 7, Section A.5.

Project name

Electronic Health Records (EHR) System

Please select the type of project

Technological needs project

If Technological Needs Project, please select the focus area(s) of the project

- Electronic health record system

Please describe the project

Providing necessary updates to infrastructure and programming to ensure appropriate access to and functionality of member EHR to facilitate the provision of services in accordance with the CalAim directive of the no wrong door policy.

Full Service Partnership Program

DHCS will provide counties with information to complete the estimated fields for eligible population and practitioners/teams needed for each EBP. The estimated numbers of teams/practitioners reflect the numbers needed to reach the entire eligible population (i.e., achieve a 100 percent penetration rate), and DHCS recognizes that counties will generally not be able to reach the entire eligible population, in consideration of BHSA funding availability. These projections are not binding and are for planning purposes only. In future guidance, DHCS will provide more information on the number of teams counties must implement to demonstrate compliance with BHSA FSP requirements. For related policy information, refer to 7.B.3 Full Service Partnership Program Requirements and 7.B.4 Full Service Partnership Levels of Care

Please review the total estimated number of individuals who may be eligible for each of the following Full Service Partnership (FSP) services (consistent with the Service Criteria in the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Evidence-Based Practice (EBP) Policy Guide, the Policy Manual Chapter 7, Section B, and forthcoming High Fidelity Wraparound (HFW)

Medi-Cal Guidance): Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT), Full Service Partnership (FSP) Intensive Case Management (ICM), HFW and Individual Placement and Support (IPS) Model of Supported Employment). Please input the estimates provided to the county in the table below

Total Adult FSP Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	265
Number of Uninsured Individuals	32
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	131

Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) Eligible Population

Please input the estimates provided to the county in the table below

ACT Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	47
Number of Uninsured Individuals	<11*

FACT Eligible Population (ACT with Justice-System Involvement)	**Estimates**
Number of Medi-Cal Enrolled Individuals	24
Number of Uninsured Individuals	3

ACT/FACT Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	<11*
Number of Teams Needed to Serve Total Eligible Population	<11*

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and Full-Time Equivalents (FTEs) (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTEs) to provide ACT and FACT over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and Technical Assistance (TA) to assist counties with completing these fields.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	0	0	0
Total Number of Teams	0	0	0

Full Service Partnership (FSP) Intensive Case Management (ICM) Eligible Population

Please input the estimates provided to the county in the table below

FSP ICM Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	194
Number of Uninsured Individuals	23

FSP ICM Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	10
Number of Teams Needed to Serve Total Eligible Population	2

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTEs) to provide FSP ICM over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and TA to assist counties with completing these fields.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	10	10	10
Total Number of Teams	2	2	2

High Fidelity Wraparound (HFW) Eligible Population

Please input the estimates provided to the county in the table below

HFW Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	58
Number of Uninsured Individuals	12

HFW Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	22
Number of Teams Needed to Serve Total Eligible Population	1

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide HFW over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and TA to assist counties with completing these fields.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	10	10	10
Total Number of Teams	1	1	1

Individual Placement and Support (IPS) Eligible Population

Please input the estimates provided to the county in the table below

IPS Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	331
Number of Uninsured Individuals	39

IPS Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	25
Number of Teams Needed to Serve Total Eligible Population	10

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide IPS over this Integrated Plan period, by fiscal year.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	0	0	0
Total Number of Teams	0	0	0

Full Service Partnership (FSP) Program Overview

Please provide the following information about the county's BHSA FSP program

Will any of the estimated number of practitioners the county plans to utilize (provided above) be responsible for providing more than one EBP?

No

Please describe how the county is employing a whole-person, trauma-informed approach, in partnership with families or an individual's natural supports

TCHSA employs a culturally competent, strength based, client and family driven, recovery and wellness

centered evidenced based approach to help people achieve a high quality of life as integrated members of the community throughout their recovery journey. With an integrative and collaborative approach, TCHSA ensures that we are addressing the issues faced by our members to best meet the needs of those we serve and provide the hope that things can and will get better.

Please describe the county's efforts to reduce disparities among FSP participants

TCHSA consistently employs bilingual service providers at all levels of the agency who are fluent in the county's single threshold language, Spanish. Additionally, the Cultural Competency Committee meets monthly to address any concerns that have been expressed to the agency. The Committee also plans, creates, and presents Cultural Competency training at the Agency quarterly meetings on a semi-annual basis (April and October).
Certified Peer Specialists provide support for individuals through the STANS Wellness & Recovery Center, delivering group and individual interactions to benefit the well-being and progress of our members. Our Member Employment Program allows individuals to engage in rehabilitative employment activities and fosters a sense of accomplishment as they learn marketable skills while earning an income.

Select which goals the county is hoping to support based on the county's allocation of FSP funding

- Access to care
- Homelessness
- Institutionalization
- Justice involvement
- Removal of children from home
- Untreated behavioral health conditions
- Care experience
- Engagement in school
- Engagement in work
- Overdoses
- Prevention of co-occurring physical health conditions
- Quality of life
- Social connection

- Suicides

Please describe what actions or activities the county behavioral health system is doing to provide ongoing engagement services to individuals receiving FSP ICM

Tehama County FSP ICM programs will engage in assertive outreach and engagement to continually engage members in their own care. Treatment plans are individualized and created in collaboration with the member increasing member engagement in their care. TCHSA works to build on members' strengths and to involve members in goal setting based on their readiness for change. TCHSA works to identify barriers to care so that strategies can be implemented to overcome those barriers. TCHSA embraces the 'whatever it takes' approach, which allows staff to be flexible with service delivery and meet clients where they are in the community. TCHSA is working toward expanding our workforce classifications to include the use of Certified Peer Support Providers. Currently, we have staff who have completed their Peer Certification, and we are working through the county process to add a job classification within the county. We have already fully implemented the peer support role with a contracted provider for unbillable services.

Ongoing engagement services is a required component of ACT, FACT, IPS, and HFW. Please describe any ongoing engagement services the county behavioral health system will provide beyond what is required of the EBP

Please describe how the county will comply with the required FSP levels of care (e.g., transition FSP ICM teams to ACT, stand up new ACT teams and/or stand up new FSP ICM teams, etc.)

Tehama County has submitted an exemption from providing ACT/FACT.

Please indicate whether the county FSP program will include any of the following optional and allowable services

No

Primary substance use disorder (SUD) FSPs

No

Outreach activities related to enrolling individuals living with significant behavioral health needs in an FSP (activities that fall under assertive field-based initiation of substance use disorder treatment services will be captured separately in the next section)

No

Other recovery-oriented services

No

If there are other services not described above that the county FSP program will include, please list them here. For team-based services, please include number of teams. If no additional FSP services, use "N/A"

Assisted Outpatient Treatment (AOT)

What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible children and youth in the development of the county's FSP program (e.g., review data, engage with stakeholders, analyze research, etc.) who are:

In, or at-risk of being in, the juvenile justice system

TCHSA will continue collaboration with stakeholders like Interagency Leadership Team, Interagency Child and Family Service Collaborative, and Justice Involved Youth, in additional to the Behavioral Health Advisory Board and Public Health Advisory Board to analyze needs of the youth within our community.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)

TCHSA has reached out to the LGBTQ+ community for collaboration concerning this Integrated Plan through surveys and public meetings. Additionally, the Cultural Competency Committee has begun the outreach process in an effort to work with advocacy groups within Northern California and locally to address the needs of those in our community.

In the child welfare system

TCHSA is partnered with the Tehama County Department of Social Services to provide support to the children of our community who are affected by mental health challenges.

What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible adults in the development of the county's FSP (e.g., review data, engage with stakeholders, analyze research, etc.) who are

Older adults

TCHSA regularly engages with stakeholders that are representatives of this demographic through our Behavioral Health Advisory Board, service providers, county partners, Homeless Navigation Center, public meetings, and surveys.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)

TCHSA has reached out to the LGBTQ+ community for collaboration concerning this Integrated Plan through surveys and public meetings. Additionally, the Cultural Competency Committee has begun the outreach process in an effort to work with advocacy groups within Northern California and locally to address the needs of those in our community.

In, or are at risk of being in, the justice system

TCHSA Behavioral Health Court is designed to connect criminal defendants with diagnosed behavioral health disorders to treatment services in the community and reduce crime recidivism by providing treatment and case management services to persons struggling with mental illness and committing criminal offenses.
Additionally, Adult Drug Court provides Substance Use treatment, community supervision, drug testing, case management, education, and housing support to individuals convicted of a crime directly related to drug and/or alcohol use. Members often have committed a felony and been sentenced to attend all drug court services in lieu of lengthy jail and/or prison time. While in drug court, participants are closely monitored by the Drug Court Judge with frequent court appearances, closely supervised by a dedicated

probation officer, and are expected to participate in a comprehensive treatment program.

Assertive Field-Based Substance Use Disorder (SUD) Questions

For related policy information, refer to 7.B.6 Assertive Field-Based Initiation for Substance Use Disorder Treatment Services

Targeted outreach

Existing programs

Homeless Outreach

Program descriptions

The Team provides both physical and preventive care while connecting patients to wrap-around services that may include behavioral health support, substance use recovery support, shelter and housing resources, medical insurance registration, and access to food and income.

Current funding source

Homeless Housing, Assistance and Prevention Grant

BHSA changes to existing programs to meet BHSA requirements

Tehama County will leverage its existing Homeless Outreach programs to expand BHSA-supported efforts focused on assertive, field-based initiation of Substance Use Disorder (SUD) treatment services. The county's homeless outreach teams—already active in encampments, shelters, motels, rural areas, and crisis locations—will integrate enhanced BHSA initiatives that allow staff to identify SUD treatment needs earlier, provide immediate engagement, and initiate treatment in the field. Outreach staff will be equipped to conduct brief screenings, facilitate same-day access to medication-assisted treatment when appropriate, and provide warm handoffs to the county's SUD providers and withdrawal management services. These teams will coordinate closely with mobile crisis units, housing navigators, peer specialists, and partnering community organizations to ensure that individuals experiencing homelessness receive low-barrier access

to SUD treatment and supportive services. BHSA funds will support training in harm reduction, trauma-informed care, and motivational interviewing to strengthen the capacity of outreach teams to engage individuals who may be ambivalent about treatment. By combining BHSA-funded SUD treatment initiatives with established homelessness outreach infrastructure, Tehama County will deliver a more proactive, responsive, and coordinated approach that connects individuals to treatment earlier, reduces overdose risk, and supports long-term stability through integrated care and housing pathways.

Expected timeline of operation

In operation

Mobile-field based programs

Existing programs

Mobile Crisis Team

Program descriptions

Provides field-based services to individuals when and where it is needed, to include any Behavioral Health service; including Substance Use Recovery and Suicide Intervention services.

Current funding source

MHSA and Medical

BHSA changes to existing programs to meet BHSA requirements

Tehama County will expand its BHSA initiatives for assertive, field-based initiation of Substance Use Disorder (SUD) treatment services by fully integrating these efforts into the county's existing Mobile Crisis and Mobile Clinic programs. The Mobile Crisis Team, already trained in rapid response, de-escalation, and field-based clinical engagement, will incorporate enhanced SUD screening, harm reduction strategies, and immediate referral or transport to SUD services when appropriate. With BHSA support, Mobile Crisis

clinicians will be equipped to initiate brief interventions, conduct same-day warm handoffs to SUD treatment providers, and coordinate directly with the county's Homeless Outreach and Access Teams to ensure continuity of care. Similarly, the Mobile Clinic—operated in partnership with physical health and behavioral health providers—will expand its capacity to deliver low-barrier SUD services in the field, including same-day assessments, medication-assisted treatment (MAT) induction when clinically appropriate, and on-site peer support education. Both mobile programs will work collaboratively to reach residents in rural and geographically isolated areas, encampments, motels, and other nontraditional settings where individuals may struggle to access clinic-based care. BHSA funding will support additional training for mobile staff in trauma informed care, motivational interviewing, cultural responsiveness, and co-occurring disorders to enhance engagement with individuals who may be reluctant to seek treatment. Through these coordinated field-based efforts, Tehama County will strengthen early identification, reduce service barriers, expand access to SUD treatment, and support long term recovery for individuals across the county's diverse communities.

Expected timeline of operation

In operation

Open-access clinics

Existing programs

TCHSA Medical Clinic

Program descriptions

Provides MAT services on an outpatient basis during regular operating hours (8:00am-5:00pm, Monday-Friday).

Current funding source

SOR-IV Grant

BHSA changes to existing programs to meet BHSA requirements

Tehama County will integrate low barrier, low threshold, rapid access to Medication-Assisted Treatment (MAT) within its Rural Health Clinic (RHC) services to ensure timely, accessible treatment for residents in remote and underserved areas. The RHCs will adopt open access scheduling models that allow same day walk in assessments and rapid initiation of MAT, including buprenorphine and naltrexone, with streamlined referrals to partnering opioid treatment programs or medication units for individuals requiring methadone. Building upon the capabilities of the Mobile Crisis and Mobile Clinic programs, RHC clinicians will be trained and equipped to conduct field-based MAT initiation and provide direct linkage back to clinic sites for follow-up care. The RHCs will strengthen collaboration with harm-reduction partners, including syringe service programs, to facilitate warm handoffs, provide safer use supplies, and maintain engagement with individuals who are hesitant to access traditional clinic environments. BHSA funding will support additional staff training in trauma informed SUD engagement, motivational interviewing, and culturally responsive practices to meet the needs of rural residents, Latino/x communities, tribal populations, older adults, and individuals experiencing homelessness. By enhancing service accessibility through open access clinics, flexible drop in options, partnerships with harm reduction providers, and rapid linkage to methadone services when appropriate, Tehama County's Rural Health Clinics will expand their capacity to deliver responsive, equitable, and low barrier MAT services that promote early intervention and long-term recovery across the county's diverse and geographically dispersed communities.

Expected timeline of operation

In operation

Targeted outreach

New programs

Nothing planned at this time

Program descriptions

N/A

Planned funding

N/A

Planned operations

N/A

Expected timeline of implementation

N/A

Mobile-field based programs

New programs

Nothing planned at this time

Program descriptions

N/A

Planned funding

N/A

Planned operations

N/A

Expected timeline of implementation

N/A

Open-access clinics

New programs

Nothing planned at this time

Program descriptions

N/A

Planned funding

N/A

Planned operations

N/A

Expected timeline of implementation

N/A

Medications for Addiction Treatment (MAT) Details
Please describe the county's approach to enabling access to same-day medications for addiction treatment (MAT) to meet the estimated population needs before July 1, 2029.

Describe how the county will assess the gap between current county MAT resources (including programs and providers) and MAT resources that can meet estimated needs

Tehama County will assess the gap between its current MAT resources and the level of services needed to meet community demand through a structured, multi step evaluation process that incorporates data analysis, provider capacity assessments, and stakeholder input. The county will begin by reviewing existing MAT programs and provider capacity across its clinics, Rural Health Clinics, contracted SUD treatment providers, and field-based programs such as the Mobile Crisis and Mobile Clinic teams. This assessment will include an inventory of current prescribers, waivered clinicians, medication units, referral pathways for methadone, and the availability of same day or open-access appointments. Concurrently, the county will analyze local epidemiological data—including overdose trends, emergency department utilization,

homelessness outreach data, law enforcement encounters, and prevalence of opioid and stimulant use disorders—to estimate the level of unmet need for MAT across geographic regions and population groups. Tehama County will supplement this data with qualitative input from community partners, individuals with lived experience, rural and tribal community stakeholders, and harm reduction organizations to identify barriers, access disparities, and community specific priorities. By comparing estimated need to current service capacity, the county will identify gaps in provider availability, medication access (including methadone), geographic reach, culturally responsive services, and field-based initiation. The findings will guide operational and funding decisions, including where to expand open-access MAT services, increase training for clinicians, strengthen referral pathways, and enhance partnerships with opioid treatment programs. Through this comprehensive assessment process, Tehama County will ensure its MAT system evolves to meet the needs of its diverse and geographically dispersed population. Tehama has the capacity to provide MAT services to youth; however, this continues to be an unmet need due to lack of awareness of program availability and services to be offered. Tehama has started conversations internally to make this service more visible in the community.

Select the following practices the county will implement to ensure same day access to MAT

- Operate MAT clinics directly
- Leverage telehealth model(s)
- Partner with neighboring counties
- Contract with MAT providers in other counties

Please provide the names of the neighboring counties the county will partner with

TCHSA will provide referrals to NTP clinics located in neighboring Shasta and/or Butte counties.

Please provide the names of other counties the contracted MAT providers are located in

TCHSA will provide referrals to NTP clinics located in neighboring Shasta and/or Butte counties.

What forms of MAT will the county provide utilizing the strategies selected above?

- Buprenorphine
- Naltrexone

Housing Interventions

Planning

For related policy information, refer to 7.C.3 Program priorities and 7.C.4 Eligible and priority populations

Please identify the biggest gaps facing individuals experiencing homelessness and at risk of homelessness with a behavioral health condition who are Behavioral Health Services Act (BHSA) eligible in the county. Please use the following definitions to inform your response: No gap – resources and connectivity available; Small gap – some resources available but limited connectivity; Medium gap – minimal resources and limited connectivity available; Large gap – limited or no resources and connectivity available; Not applicable – county does not have setting and does not consider there to be a gap. Counties should refer to their local Continuum of Care (CoC) Housing Inventory Count (HIC) to inform responses to this question.

Supportive housing

Medium gap

Apartments, including master-lease apartments

Medium gap

Single and multi-family homes

Large gap

Housing in mobile home communities

Medium gap

(Permanent) Single room occupancy units

Medium gap

(Interim) Single room occupancy units

Medium gap

Accessory dwelling units, including junior accessory dwelling units

Not applicable

(Permanent) Tiny homes

Medium gap

Shared housing

Medium gap

(Permanent) Recovery/sober living housing, including recovery-oriented housing

Not applicable

(Interim) Recovery/sober living housing, including recovery-oriented housing

Not applicable

Assisted living facilities (adult residential facilities, residential facilities for the elderly, and licensed board and care)

Small gap

License-exempt room and board

Not applicable

Hotel and Motel stays

Medium gap

Non-congregate interim housing models

Medium gap

Congregate settings that have only a small number of individuals per room and sufficient common space (does not include behavioral health residential treatment settings)

Medium gap

Recuperative Care

Medium gap

Short-Term Post-Hospitalization housing

Medium gap

(Interim) Tiny homes, emergency sleeping cabins, emergency stabilization units

Medium gap

Peer Respite

Not applicable

Permanent rental subsidies

Large gap

Housing supportive services

Medium gap

What additional non-BHSA resources (e.g., county partnerships, vouchers, data sharing agreements) or funding sources will the county behavioral health system utilize (local, state, and federal) to expand supply and/or increase access to housing for BHSA eligible individuals?

TCHSA has partnered with two developers to bring a total of 88 apartment units into the City of Red Bluff, the county seat, through No Place Like Home (NPLH) and Homekey+ initiatives. These will include 86 units with project-based vouchers, 50 Low-Income housing units, 10 NPLH units, 13 Homekey+ units, and 13 NPLH/Homekey+ units. Additionally, TCHSA has partnered with the P.A.T.H. Navigation center through a BHBH Grant to provide transitional housing solutions to those in need.

How will BHSA Housing Interventions intersect with those other resources and supports to strengthen or expand the continuum of housing supports available to BHSA eligible individuals?

TCHSA will employ Case Resource Specialists to provide supportive services to our members, assisting them with transitioning to and maintaining positive housing solutions through appropriate Housing Interventions.
TCHSA has completed and put in operation one No Place Like Home (NPLH) housing complex and is currently partnered with two other developers for additional NPLH projects. Additionally, we have a Behavioral Health Bridge Housing grant that we are working collaboratively with our Continuum of Care and our homeless Navigation Center to bring more transitional housing to the area. TCHSA and our MCP, Partnership Healthplan of California, are actively working on the Transitional Rent Medi-Cal benefit for an additional layer of support for our community members in need.

What is the county behavioral health system's overall strategy to promote permanent housing placement and retention for individuals receiving BHSA Housing Interventions?

TCHSA will employ Case Resource Specialists to provide supportive services to our members, assisting them with transitioning to and maintaining positive housing solutions through appropriate Housing Interventions.
TCHSA has completed and put in operation one No Place Like Home (NPLH) housing complex and is currently partnered with two other developers for additional NPLH projects. Additionally, we have a Behavioral Health Bridge Housing grant that we are working collaboratively with our Continuum of Care

and our homeless Navigation Center to bring more transitional housing to the area. TCHSA and our MCP, Partnership Healthplan of California, are actively working on the Transitional Rent Medi-Cal benefit for an additional layer of support for our community members in need.

What actions or activities is the county behavioral health system engaging in to connect BHSA eligible individuals to and support permanent supportive housing (PSH) (e.g., rental subsidies for individuals residing in PSH projects, operating subsidies for PSH projects, providing supportive services to individuals in other permanent housing settings, capital development funding for PSH)?

TCHSA has partnered with two developers to bring a total of 88 apartment units into the City of Red Bluff, the county seat, through No Place Like Home (NPLH) and Homekey+ initiatives. These will include 86 units with project-based vouchers, 50 Low-Income housing units, 10 NPLH units, 13 Homekey+ units, and 13 NPLH/Homekey+ units. Additionally, TCHSA has partnered with the P.A.T.H. Navigation center through a BHBH Grant to provide transitional housing solutions to those in need. Also, PLHA funds will be utilized by the P.A.T.H. Navigation Center in assisting participants to obtain and retain housing through supportive services that include case management, resource navigation, and connections to medical, mental health, and substance use recovery services.

Please describe how the county behavioral health system will ensure all Housing Interventions settings provide access to clinical and supportive behavioral health care and housing services

TCHSA will employ Case Resource Specialists (CRS) to provide supportive services to our members, assisting them with transitioning to and maintaining positive housing solutions through appropriate Housing Interventions.
TCHSA CRS can assist members in acquiring access to any Behavioral Health Service that is appropriate to the member's needs, including, but not limited to: clinical, rehab, group, and supportive services.

Eligible Populations

Please describe how the county behavioral health system will identify, screen, and refer individuals eligible for BHSA Housing Interventions

Referrals will be submitted through the member's Case Manager when members are identified as individuals needing assistance with housing. All applications for supportive housing are required to go through the County Coordinated Entry System (CES) and Homeless Management Information System (HMIS) which are accessed through 2-1-1 and/or a housing navigator located at the P.A.T.H. Navigation Center. Individuals in the HMIS are assigned a VISPDAT score based on their answers to the CES Housing Assessment Questionnaire and are placed into HMIS based on that score. Housing providers are required to serve the most vulnerable (including chronically homeless) individuals first in accordance with fair housing laws and state guidance.
TCHSA and our MCP, Partnership Healthplan of California, are actively working on the Transitional Rent Medi-Cal benefit for an additional layer of support for our community members in need.

Will the county behavioral health system provide BHSA-funded Housing Interventions to individuals living with a substance use disorder (SUD) only?

Yes

What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible children and youth in the development of the county's Housing Interventions services (e.g., review data, engage with stakeholders, analyze research, etc.) who are:

In, or at-risk of being in, the juvenile justice system

TCHSA hosted town halls, community meetings/trainings, focus groups, and delivered surveys throughout the community during the BHSA CPPP (see uploaded documents under the CPPP for complete details of responses).

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)

TCHSA hosted town halls, community meetings/trainings, focus groups, and delivered surveys throughout the community during the BHSA CPPP (see uploaded documents under the CPPP for complete details of responses).

In the child welfare system

TCHSA hosted town halls, community meetings/trainings, focus groups, and delivered surveys throughout the community during the BHSA CPPP (see uploaded documents under the CPPP for complete details of responses).

What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible adults in the development of the county's Housing Interventions services (e.g., review data, engage with stakeholders, analyze research, etc.) who are

Older adults

TCHSA hosted town halls, community meetings/trainings, focus groups, and delivered surveys throughout the community during the BHSA CPPP (see uploaded documents under the CPPP for complete details of responses).

In, or are at risk of being in, the justice system

TCHSA hosted town halls, community meetings/trainings, focus groups, and delivered surveys throughout the community during the BHSA CPPP (see uploaded documents under the CPPP for complete details of responses).

In underserved communities

TCHSA hosted town halls, community meetings/trainings, focus groups, and delivered surveys throughout the community during the BHSA CPPP (see uploaded documents under the CPPP for complete details of responses).

Local Housing System Engagement

How will the county behavioral health system coordinate with the Continuum of Care (CoC) and receive referrals for Housing Interventions services?

TCHSA has a close working collaboration with the Tehama County CoC, and has 1-3 individuals who are

capable of accessing the CES and HMIS.
TCHSA Housing Coordinator attends the Housing & Homeless Stakeholders Committee Meetings, General CoC Meeting, Executive Council Committee Meeting, and 4 CoC workgroups on a monthly basis in order to contribute to the County's 10-Year Plan to end Homelessness. Additionally, TCHSA hosts a Community Partner Resource Networking meeting on the first Wednesday and Friday of each month which allows all direct service providers in the county to convene and share resources and contact information in an effort to streamline our community's access to services, including housing and housing services.

Please describe the county behavioral health system's approach to collaborating with the local CoC, Public Housing Agencies, Medi-Cal managed care plans (MCPs), Enhanced Care Management (ECM) and Community Supports providers, as well as other housing partners, including existing and prospective PSH developers and providers in your community in the implementation of the county's Housing Interventions

Local CoC

Tehama County CoC (Vitality Project)
TCHSA has a close working collaboration with the Tehama County CoC, and has 1-3 individuals who are capable of accessing the CES and HMIS.
TCHSA Housing Coordinator attends the Housing & Homeless Stakeholders Committee Meetings, General CoC Meeting, Executive Council Committee Meeting, and 4 CoC workgroups on a monthly basis in order to contribute to the County's 10-Year Plan to end Homelessness. Additionally, TCHSA hosts a Community Partner Resource Networking meeting on the first Wednesday and Friday of each month which allows all direct service providers in the county to convene and share resources and contact information in an effort to streamline our community's access to services, including housing and housing services.

Public Housing Agency

Plumas County Housing Authority has partnered with TCHSA to provide project-based vouchers for our two new NPLH projects that will be under construction through 2026, with an expected lease-up in mid-2027.

MCPs

TCHSA and our MCP, Partnership Healthplan of California, are actively working on the Transitional Rent Medi-Cal benefit for an additional layer of support for our community members in need.

ECM and Community Supports Providers

Victor Community Support Services has a contract with TCHSA to provide outpatient SMHS to youth and families in homes, schools, community, office based, and telehealth modalities.

Other (e.g., CalWORKS/TANF housing programs, child welfare housing programs, PSH developers and providers, etc.)

How will the county behavioral health system work with Homekey+ and supportive housing sites to provide services, funding, and referrals that support and house BHSA eligible individuals?

TCHSA has a NPLH/Homekey+ project under way in Red Bluff, CA; expected lease-up dates mid 2027. TCHSA and our MCP, Partnership Healthplan of California, are actively working on the Transitional Rent Medi-Cal benefit for an additional layer of support for our community members in need.

Did the county behavioral health system receive Homeless Housing Assistance and Prevention Grant Program (HHAP) Round 6 funding?

Yes

How will the county coordinate the use of HHAP dollars to support the housing needs of BHSA eligible individuals in your community?

In collaboration with Tehama CoC, TCHSA will provide Supportive Services to address the housing needs of the BHSA eligible individuals in our community when members are identified as individuals in need of housing through the HMIS.

BHSA Housing Interventions Implementation

The following questions are specific to BHSA Housing Interventions funding (no action needed). For more information, please see 7.C.9 Allowable expenditures and related requirements

Rental Subsidies(Chapter 7. Section C.9.1)

The intent of Housing Interventions is to provide rental subsidies in permanent settings to eligible individuals for as long as needed, or until the individual can be transitioned to an alternative permanent housing situation or rental subsidy source. (no action needed)

Is the county providing this intervention?

Yes

Is the county providing this intervention to chronically homeless individuals?

Yes

How many individuals does the county behavioral health system expect to serve with rental subsidies under BHSA Housing Interventions on an annual basis?

Gentry House - <11* individuals, Permanent Supportive Housing - 12 (25% of the total projected PSH units beginning FY 27-28). Other individuals will be determined on a case-by-case basis and will be determined through appropriate triage practices in order to assist members with acquiring and maintaining housing.

How many of these individuals will receive rental subsidies for permanent housing on an annual basis?

20

How many of these individuals will receive rental subsidies for interim housing on an annual basis?

25

What is the county's methodology for estimating total rental subsidies and total number of

individuals served in interim and permanent settings on an annual basis?

Individuals at Gentry House are likely to need temporary assistance with housing. PSH units determined at 25% of total units beginning FY 27-28. Other individuals will be determined on a case-by-case basis and will be determined through appropriate triage practices in order to assist members with acquiring and maintaining housing.

For which setting types will the county provide rental subsidies?

- Non-Time-Limited Permanent Settings: Supportive housing
- Non-Time-Limited Permanent Settings: Apartments, including master-lease apartments
- Non-Time-Limited Permanent Settings: Single and multi-family homes
- Non-Time-Limited Permanent Settings: Housing in mobile home communities
- Non-Time-Limited Permanent Settings: Single room occupancy units
- Non-Time-Limited Permanent Settings: Accessory dwelling units, including Junior Accessory Dwelling Units
- Non-Time-Limited Permanent Settings: Tiny Homes
- Non-Time-Limited Permanent Settings: Shared housing
- Non-Time-Limited Permanent Settings: Recovery/Sober Living housing, including recovery-oriented housing
- Non-Time-Limited Permanent Settings: Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
- Non-Time-Limited Permanent Settings: License-exempt room and board
- Non-Time-Limited Permanent Settings: Other settings identified under the Transitional Rent benefit
- Time Limited Interim Settings: Hotel and motel stays
- Time Limited Interim Settings: Non-congregate interim housing models
- Time Limited Interim Settings: Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls)[134] (does not include behavioral health residential treatment settings)
- Time Limited Interim Settings: Recuperative Care
- Time Limited Interim Settings: Short-Term Post-Hospitalization housing
- Time Limited Interim Settings: Tiny homes, emergency sleeping cabins, emergency stabilization units
- Time Limited Interim Settings: Peer respite

- Time Limited Interim Settings: Other settings identified under the Transitional Rent benefit

Will this Housing Intervention accommodate family housing?

Yes

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding

Rental Subsidies will be considered on a case-by-case basis and will be determined through appropriate triage practices in order to assist members with acquiring and maintaining housing.

Will the county behavioral health system provide rental assistance through project-based (tied to a particular unit) or tenant-based (tied to the individual) subsidies?

- Tenant-based

How will the county behavioral health system identify a portfolio of available units for placing BHSA eligible individuals, including in collaboration with other county partners and as applicable, Flex Pools (e.g., Master Leasing)? Please include partnerships and collaborative efforts your county behavioral health system will engage in

Shared Housing (Gentry House) is contracted with TCHSA, with services provided by Case Managers. PSH units are contracted with TCHSA through NPLH 55-year service-provision agreements. Other rental subsidies will be determined on a case-by-case basis, and will be determined through appropriate triage practices in order to assist members with acquiring and maintaining housing. THCSA will continue to build relationships with the various property management agencies and housing entities throughout the county.

Total number of units funded with BHSA Housing Interventions per year

45

Please provide additional details to explain if the county is funding rental subsidies with BHSA

Housing Interventions that are not tied to a specific number of units

These funds will allow TCHSA to assist members wherever they are housed, and are not limited to a specific location within the county in order to better serve those individuals who need assistance with maintaining/obtaining housing.

Operating Subsidies(Chapter 7, Section C.9.2)

Is the county providing this intervention?

Yes

Is the county providing this intervention to chronically homeless individuals?

Yes

Anticipated number of individuals served per year

55

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding

Per the Policy Manual Chapter 7.C.9.3, TCHSA will provide operating subsidies to a Shared Housing facility (Gentry House) according to the Policy Manual Chapter 7.C.9.2 in the form of costs associated with the day-to-day physical operation of housing projects and may include utilities (including internet), maintenance and repairs, marketing and leasing costs taxes and insurance, property management, office supplies and expenses, legal and accounting services, security and/or site monitors, cleaning fees, and housing incidentals (refrigerators/appliances, water heater, transportation, furnishings, food, hygiene products etc.). Behavioral health services provided to members by TCHSA Case Resource Specialists will be funded through BHSS in accordance with the Policy Manual. These funds will also allow TCHSA to assist members wherever they are housed, and are not limited to a specific location within the county in order to better serve those individuals who need assistance with maintaining/obtaining housing. Other individuals will be

determined on a case-by-case basis and will be determined through appropriate triage practices in order to assist members with acquiring and maintaining housing.

For which setting types will the county provide operating subsidies?

- Non-Time-Limited Permanent Settings: Supportive housing
- Non-Time-Limited Permanent Settings: Apartments, including master-lease apartments
- Non-Time-Limited Permanent Settings: Single and multi-family homes
- Non-Time-Limited Permanent Settings: Housing in mobile home communities
- Non-Time-Limited Permanent Settings: Single room occupancy units
- Non-Time-Limited Permanent Settings: Accessory dwelling units, including Junior Accessory Dwelling Units
- Non-Time-Limited Permanent Settings: Tiny Homes
- Non-Time-Limited Permanent Settings: Shared housing
- Non-Time-Limited Permanent Settings: Recovery/Sober Living housing, including recovery-oriented housing
- Non-Time-Limited Permanent Settings: Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
- Non-Time-Limited Permanent Settings: License-exempt room and board
- Non-Time-Limited Permanent Settings: Other settings identified under the Transitional Rent benefit
- Time Limited Interim Settings: Hotel and motel stays
- Time Limited Interim Settings: Non-congregate interim housing models
- Time Limited Interim Settings: Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls)[134] (does not include behavioral health residential treatment settings)
- Time Limited Interim Settings: Recuperative Care
- Time Limited Interim Settings: Short-Term Post-Hospitalization housing
- Time Limited Interim Settings: Tiny homes, emergency sleeping cabins, emergency stabilization units
- Time Limited Interim Settings: Peer respite
- Time Limited Interim Settings: Other settings identified under the Transitional Rent benefit

Will this be a scattered site initiative?

Yes

Will this Housing Intervention accommodate family housing?

Yes

Total number of units funded with BHSA Housing Interventions per year

45

Please provide additional details to explain if the county is funding operating subsidies with BHSA Housing Interventions that are not tied to a specific number of units

These funds will allow TCHSA to assist members wherever they are housed, and are not limited to a specific location within the county in order to better serve those individuals who need assistance with maintaining/obtaining housing.

Landlord Outreach and Mitigation Funds(Chapter 7, Section C.9.4.1)

Is the county providing this intervention?

No

Please explain why the county is not providing this intervention

TCHSA partners build operating subsidies into their budgets, and additional county funding is not applicable. Additionally, BHBH funding will be employed through FY 26-27 rather than BHSA Housing.

Participant Assistance Funds(Chapter 7, Section C.9.4.2)

Is the county providing this intervention?

No

Please explain why the county is not providing this intervention

BHBH funding will be employed for this service, not BHSA Housing due to limited funding.

Housing Transition Navigation Services and Tenancy Sustaining Services(Chapter 7, Section C.9.4.3)

Pursuant to Welfare and Institutions (W&I) Code section 5830, subdivision (c)(2), BHSA Housing Interventions may not be used for housing services covered by Medi-Cal MCP. Please select Yes only if the county is providing these services to individuals who are not eligible to receive the services through their Medi-Cal MCP (no action needed)

Is the county providing this intervention?

No

Please explain why the county is not providing this intervention

This service is funded through the Managed Care Plan and by BHBH funding.

Housing Interventions Outreach and Engagement(Chapter 7, Section C.9.4.4)

Is the county providing this intervention?

No

Please explain why the county is not providing this intervention

Outreach and Engagement for housing services is funded through other sources such as PLHA, BHBH, and ESG funds.

Capital Development Projects(Chapter 7, Section C.10)

Counties may spend up to 25 percent of BHSA Housing Interventions on capital development projects. Will the county behavioral health system use BHSA Housing Interventions for capital development projects?

No

Please explain why the county is not providing this intervention

TCHSA is currently partnered with one completed NPLH project and two NPLH projects entering construction in FY 2025-26.

Other Housing Interventions

If the county is providing another type of Housing Interventions not listed above, please describe the intervention

Is the county providing this intervention to chronically homeless individuals?

Anticipated number of individuals served per year

Continuation of Existing Housing Programs

Please describe if any BHSA Housing Interventions funding will be used to support the continuation of housing programs that are ending (e.g., Behavioral Health Bridge housing)

Yes, BHSA Housing Intervention funds will be employed to continue BHBH programs in years 2 and 3 of this Integrated Plan.

Relationship to Housing Services Funded by Medi-Cal Managed Care Plans

For more information, please see 7.C.7 Relationship to Medi-Cal Funded Housing Services

Which of the following housing-related Community Supports is the county behavioral health system an MCP-contracted provider of?

- None of the Above

For which of the following services does the county behavioral health system plan to become an MCP-contracted provider of?

Housing Transition Navigation Services

No

Housing Deposits

No

Housing Tenancy and Sustaining Services

No

Short-Term Post-Hospitalization Housing

No

Recuperative Care

No

Day Habilitation

No

Transitional Rent

No

How will the county behavioral health system identify, confirm eligibility, and refer Medi-Cal

members to housing-related Community Supports covered by MCPs (including Transitional Rent)?

Tehama County Health Services Agency, Behavioral Health will refer clients for Community Supports to the Managed Care Provider as needed and in compliance with all associated referral processes.
TCHSA and our MCP, Partnership Healthplan of California, are actively working on the Transitional Rent Medi-Cal benefit for an additional layer of support for our community members in need. No mechanisms to identify, screen, and refer Medi-Cal eligible individuals have been finalized at this time.

Please describe coordination efforts and ongoing processes to ensure the county behavioral health contracted provider network for Housing Interventions is known and shared with MCPs serving your county

TCHSA is currently coordinating with our MCP and potential CS vendors. TCHSA and our MCP, Partnership Healthplan of California, are actively working on the Transitional Rent Medi-Cal benefit for an additional layer of support for our community members in need. No mechanisms to identify, screen, and refer Medi-Cal eligible individuals have been finalized at this time.

Does the county behavioral health system track which of its contracted housing providers are also contracted by MCPs for housing-related Community Supports (provided in questions #1 and #2 above)?

No

What processes does the county behavioral health system have in place to ensure Medi-Cal members living with significant behavioral health conditions do not experience gaps in service once any of the MCP housing services are exhausted, to the extent resources are available?

The majority of individuals that qualify for MCP housing services are connected to TCHSA services or the P.A.T.H. Navigation Center (shelter). TCHSA and P.A.T.H. continue to nurture a collaborative working relationship to ensure that those who are experiencing challenges have access to services.
TCHSA and our MCP, Partnership Healthplan of California, are actively working on the Transitional Rent

Medi-Cal benefit for an additional layer of support for our community members in need. No mechanisms to identify, screen, and refer Medi-Cal eligible individuals have been finalized at this time.

Flexible Housing Subsidy Pools

Flexible Housing Subsidy Pools ("Flex Pools") are an effective model to streamline and simplify administering rental assistance and related housing supports. DHCS released the Flex Pools TA Resource Guide that describes this model in more detail linked here: Flexible Housing Subsidy Pools - Technical Assistance Resource. Please reference the TA Resource Guide for descriptions of the Flex Pool model and roles referenced below including the Lead Entity, Operator, and Funder.

For related policy information, refer to 7.C.8 Flexible Housing Subsidy Pools.

Is there an operating Flex Pool (or elements of a Flex Pool, which includes (1) coordinating and braiding funding streams, (2) serving as a fiscal intermediary, (3) identifying, securing, and supporting a portfolio of units for participants, and/or (4) coordinating with providers of housing supportive services) in the county (please refer to DHCS' Flex Pools TA Resource Guide)?

No

Is the county behavioral health system involved in planning efforts to launch a Flex Pool in the county?

No

Please describe any other roles and functions the county behavioral health system plans to take to support the operations or launch and scaling of a Flex Pool in addition to those described above

N/A

Behavioral Health Services Fund: Innovative Behavioral Health

Pilot and Projects

For each innovative program or pilot provide the following information. If the county provides more than one program, use the "Add additional program" button. For related policy information, refer to 7.A.6 Innovative Behavioral Health Pilots and Projects.

Does the county's plan include the development of innovative programs or pilots?

No

Workforce Strategy

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 6.C.2 Securing Medi-Cal Payment.

Maintain an Adequate Network of Qualified and Culturally Responsive Providers

The county must ensure its county-operated and county-contracted behavioral health workforce is well-supported and culturally and linguistically responsive with the population to be served. Through existing Medi-Cal oversight processes, the Department of Health Care Services (DHCS) will assess whether the county:

The county must ensure that Behavioral Health Services Act (BHSA)-funded providers are qualified to deliver services, comply with nondiscrimination requirements, and deliver services in a culturally competent manner. Effective FY 2027-2028, DHCS encourages counties to require their BHSA providers to comply with the same standards as Medi-Cal providers in these areas (i.e. requiring the same standards regardless of whether a given service is reimbursed under BHSA or Medi-Cal), as described in the Policy Manual.

Does the county intend to adopt this recommended approach for BHSA-funded providers that also participate in the county's Medi-Cal Behavioral Health Delivery System?

Yes

Does the county intend to adopt this recommended approach for BHSA-funded providers that do not participate in the county's Medi-Cal Behavioral Health Delivery System?

Yes

Build Workforce to Address Statewide Behavioral Health Goals

For related policy information, refer to 3.A.2 Contents of Integrated Plan and 7.A.4 Workforce Education and Training

Assess Workforce Gaps

What is the overall vacancy rate for permanent clinical/direct service behavioral health positions in the county (including county-operated providers)?

50

Upload any data source(s) used to determine vacancy rate

For county behavioral health (including county-operated providers), please select the five positions with the greatest vacancy rates

- Licensed Clinical Social Worker
- Mental Health Rehabilitation Specialist
- Licensed Marriage and Family Therapist
- Licensed Professional Clinical Counselor
- Substance Use Disorder Counselor

Please describe any other key workforce gaps in the county

No other identified workforce gaps at this time.

How does the county expect workforce needs to shift over the next three fiscal years given new and forthcoming requirements, including implementation of new evidence-based practices under Behavioral Health Transformation (BHT) and Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT)?

TCHSA expects to continue to recruit and strive to retain, qualified individuals who are dedicated to providing services to our members. These strategies include, but are not limited to, the development and

training of Community Health Workers, EMDR and Flash Technique training for TCHSA therapists, and the CSC for FEP implementation and training requirements. TCHSA CSC for FEP team is continually working with the Center of Excellence, and all currently assigned CSC for FEP members have been trained according to their designated functions.

Tehama County is an equal opportunity employer and values diversity within our organization. We do not discriminate on the basis of race, religion, color, national origin, gender, sexual orientation, age, marital status, veteran status, or disability status. We will ensure that individuals with disabilities are provided with reasonable accommodations to participate in the job application, examination, and interview process, to perform essential job functions, and to receive other benefits and privileges of employment.
TCHSA will provide training to the behavioral health workforce as needed to further the goals of the new BHSA programs/requirements as capacity permits without the interruption of services to our current members.

Address Workforce Gaps

If the county is planning to leverage the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative to address workforce gaps including for FSP and CSC for FEP, such as through applying for and/or encouraging providers to apply for the following BH-CONNECT workforce programs, please specify below.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Scholarship Program?

Yes

Please explain any actions or activities the county is engaging in to leverage the program

Ensuring prospective applicants are aware of the opportunity, and providing them with the support, training, and direction needed to be successful.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Student Loan Payment Program?

Yes

Please explain any actions or activities the county is engaging in to leverage the program

Ensuring prospective applicants are aware of the opportunity, and providing them with the support, training, and direction needed to be successful.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Recruitment and Retention Program?

No

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Community-Based Provider Training Program?

Yes

Please explain any actions or activities the county is engaging in to leverage the program

Ensuring prospective applicants are aware of the opportunity, and providing them with the support, training, and direction needed to be successful.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Residency Program?

No

Please describe any other efforts underway or planned in the county to address workforce gaps aside from those already described above under Behavioral Health Services Act Workforce, Education, and Training

Recruitment efforts for hard-to-fill positions are ongoing, including the formation of eligibility lists once

positions are filled. Staff-specific training is being pursued in an effort to increase retention.

Budget and Prudent Reserve

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 6.B.3 Local Prudent Reserve.

Budget and Prudent Reserve

Download and complete the budget template using the button below before starting this section

Please upload the completed budget template

- Tehama Integrated-Plan-Budget-Template_v3_2026.9.25.xlsx

Please upload supporting data

Please indicate how the county plans to spend the amount over the maximum allowed prudent reserve limit for each component if the county indicated they would allocate excess prudent reserve funds to a given Behavioral Health Services Act component in Table Nine of the budget template

Behavioral Health Services and Supports (BHSS)

0

Full Service Partnership (FSP)

0

Housing Interventions

0

Enter date of last prudent reserve assessment

10/17/2025

Please describe how the use of excess prudent reserve funds drawn down from the local prudent reserve aligns with the goals of the Integrated Plan

BHSS

0

FSP

0

Housing Interventions

0

Plan Approval and Compliance

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 3.A.1 Reporting Period

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Behavioral health director certification

Download and complete the behavioral health director certification template using the button below before starting this section

Please upload the completed Behavioral health director certification template

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County administrator or designee certification

Download and complete the county administrator or designee certification template using the button below before starting this section

Please upload the completed County administrator or designee certification template

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Board of supervisor certification

For final submission, download and complete the board of supervisor certification template using the button below before starting this section

Please upload the completed Board of supervisor certification template

Requests

Behavioral Health Services Fund (BHSF) Housing Intervention Component

What percentage of funds is the county requesting to utilize for the Housing Intervention Component?

10

Of the percentage of funds above or below the required 30 percent being utilized for Housing Interventions, identify which allocation components and the percentage the funding will transfer from or into

Components	Percentage of funds transferring
Full Service Partnerships	10
Behavioral Health Services and Supports	10

Please select which Housing Interventions exemptions criteria the county meets

- Very significant or very limited need (e.g., small/large eligible population)
- Sufficient/insufficient funding from other sources to address housing needs

Please provide justification for your request

TCHSA has completed and put in operation one No Place Like Home (NPLH) housing complex and is currently partnered with two other developers for additional NPLH projects. Additionally, we have a Behavioral Health Bridge Housing grant that we are working collaboratively with our Continuum of Care and our homeless Navigation Center to bring more transitional housing to the area. TCHSA and our MCP, Partnership Healthplan of California, are actively working on the Transitional Rent Medi-Cal benefit for an additional layer of support for our community members in need.
With staffing of TCHSA being significantly low, about 50%, we would not be able to adequately administer additional Housing Interventions at this time.

Supporting data

Please upload supporting data

What is the data source?

Other

Other

BHBH Grant

Supporting data

Please upload supporting data

What is the data source?

Housing inventory count

Supporting data

Please upload supporting data

What is the data source?

Housing inventory count

Supporting data

Please upload supporting data

What is the data source?

Other

Other

MOU with PSH NPLH project

Assertive Community Treatment (ACT)

For counties seeking an exemption to the requirement to include ACT in the county's FSP program

Please select which FSP exemptions criteria the county meets

- Limited workforce (e.g. qualified providers)

Please provide justification for this FSP exemption request

Historically, TCHSA BH has had a 65% vacancy rate over the past several years. In addition to these vacancy rates, due to the rural nature of our community, being able to offer this EBP to fidelity over the next 3 years would be a heavy demand for our current staffing patterns/ratios; as well as limited resources and organizational provider capacity.

Supporting Data

Please upload supporting data

Please select the data source

- Other

Please describe

Tehama County Estimates for ACT, FACT, and FSP ICM according to the attached document from the California Department of Healthcare Services (DHCS), outlines that there would be a need for 10 practitioners to facilitate the delivery of services. TCHSA BH does not have the additional personnel needed to staff these programs.

Forensic Assertive Community Treatment (FACT)

For counties seeking an exemption to the requirement to include FACT in the county's FSP program

Please select which FSP exemptions criteria the county meets

- Limited workforce (e.g. qualified providers)

Please provide justification for this FSP exemption request

Historically, TCHSA BH has had a 65% vacancy rate over the past several years. In addition to these vacancy rates, due to the rural nature of our community, being able to offer this EBP to fidelity over the next 3 years would be a heavy demand for our current staffing patterns/ratios; as well as limited resources and organizational provider capacity.

Supporting Data

Please upload supporting data

Please select the data source

- Other

Please describe

Tehama County Estimates for ACT, FACT, and FSP ICM according to the attached document from the

California Department of Healthcare Services (DHCS), outlines that there would be a need for 10 practitioners to facilitate the delivery of services. TCHSA BH does not have the additional personnel needed to staff these programs.

Individual Placement and Support (IPS) Supported Employment

For counties seeking an exemption to the requirement to include IPS in the county's FSP program

Please select which FSP exemptions criteria the county meets

- Limited workforce (e.g. qualified providers)

Please provide justification for this FSP exemption request

Historically, TCHSA BH has had a 65% vacancy rate over the past several years. In addition to these vacancy rates, due to the rural nature of our community, being able to offer this EBP to fidelity over the next 3 years would be a heavy demand for our current staffing patterns/ratios; as well as limited resources and organizational provider capacity.

Supporting Data

Please upload supporting data

Please select the data source

- Other

Please describe

Tehama County Estimates for ACT, FACT, and FSP ICM according to the attached document from the California Department of Healthcare Services (DHCS), outlines that there would be a need for 25

practitioners to facilitate the delivery of services. TCHSA BH does not have the additional personnel needed to staff these programs.

Data Suppression Notice:

Values marked with "*" have been suppressed per DHCS de-identification standards. Counts between 1–10 are displayed as "<11*"

APPENDIX

Instructions

Counties shall report their planned expenditures for all behavioral health funding sources, not limited to only BHSA, along the Behavioral Health Care Continuum in Tab One.
For Annual Updates, counties should review and make updates only to the next fiscal year. For Intermittent Updates, counties should review and make updates to the current fiscal year.
Column C: counties shall indicate whether they provide each category of services using the check box.
Columns D through I: counties shall include their estimated total expenditures for the Integrated Plan period across all behavioral health funding sources and programs by each Behavioral Health Care Continuum category. Counties should consider children/youth as 21 and under for Columns G - I.
Columns J and K: counties shall input their estimated total count of all individuals served through the county behavioral health system across all funding sources/programs. These counts may be duplicated. Counties should consider eligible children/youth as 21 and under for Column K.
Row 38: the total projected expenditures in columns D through I and total projected individuals served annually in columns J and K will be auto-populated from rows 20 through 36.
Note: For a list of all funding streams that should be included in the projected expenditures calculation for each BH Care Continuum Category, please see the Behavioral Health Services Act (BHSA) County Policy Manual Chapter 3, Section A.
Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table One: Behavioral Health Care Continuum Projected Expenditures

	Services Are Provided in County	Total Projected Expenditures On Adults and Older Adults (Year One)	Total Projected Expenditures On Adults and Older Adults (Year Two)	Total Projected Expenditures On Adults and Older Adults (Year Three)	Total Projected Expenditures on Children/Youth (under 21) (Year One)	Total Projected Expenditures on Children/Youth (under 21) (Year Two)	Total Projected Expenditures on Children/Youth (under 21) (Year Three)	Projected Individuals to be Served Annually (May be duplicated) Eligible Adults and Older Adults	Projected Individuals to be Served Annually (May be duplicated) Eligible Children/Youth (under 21)
Substance Use Disorder (SUD) Services									
Primary Prevention Services	☑	$ 253,950.00	$ 266,756.00	$ 279,205.00	$ 66,000.00	$ 66,000.00	$ 66,000.00	94.00	50.00
Early Intervention Services	☑	$ 1,903,643.00	$ 1,954,635.00	$ 1,987,462.00	$ 131,366.00	$ 137,410.00	$ 141,675.00	299	32.00
Outpatient Services	☑	$ 761,188.00	$ 794,049.00	$ 827,703.00	$ 54,000.00	$ 56,563.00	$ 58,569.00	299	32.00
Intensive Outpatient Services	☑	$ 332,519.00	$ 348,640.00	$ 359,919.00	$ 6,735.00	$ 6,284.00	$ 6,507.00	94	10.00
Crisis and Field-Based Services	☑	$ 250,000.00	$ 250,000.00	$ 250,000.00	$ 22,000.00	$ 22,000.00	$ 22,000.00	50	25.00
Residential Treatment Services	☑	$ 120,000.00	$ 126,000.00	$ 132,300.00	$ 10,000.00	$ 10,500.00	$ 11,025.00	15	1.00
Inpatient Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	0	0.00
Mental Health (MH) Services									
Primary Prevention Services	☑	$ 253,950.00	$ 266,756.00	$ 279,205.00	$ 253,950.00	$ 266,756.00	$ 279,205.00	150	150
Early Intervention Services	☑	$ 4,007,891.00	$ 4,066,438.00	$ 4,122,590.00	$ 4,171,478.00	$ 4,232,414.00	$ 4,290,858.00	3288	3424
Outpatient and Intensive Outpatient Services	☑	$ 4,266,125.00	$ 4,289,639.00	$ 4,313,449.00	$ 4,011,050.00	$ 4,160,744.00	$ 4,318,920.00	1206	1056
Crisis Services	☑	$ 1,674,085.00	$ 1,722,574.00	$ 1,768,357.00	$ 1,742,415.00	$ 1,792,885.00	$ 1,840,536.00	980	1020
Residential Treatment Services	☑	$ 32,547.00	$ 34,174.00	$ 35,883.00	$ 13,259.00	$ 13,922.00	$ 14,618.00	7	3
Hospital and Acute Services	☑	$ 618,397.00	$ 649,317.00	$ 681,783.00	$ 251,931.00	$ 264,528.00	$ 277,754.00	135	55
Subacute and Long-Term Care Services	☑	$ 120,000.00	$ 126,000.00	$ 132,300.00	$ -	$ -	$ -	20	0
Housing Services (MH + SUD)									
Housing Services	☑	$ 565,854.00	$ 627,593.00	$ 685,328.00	$ -	$ -	$ -	5	0
Total Projected Expenditures and Individuals Served									
Total Projected Expenditures and Individuals Served (auto-populated)		$ 15,160,149.00	$ 15,522,571.00	$ 15,855,484.00	$ 10,734,184.00	$ 11,030,006.00	$ 11,327,667.00	6642	5858

Instructions

Counties shall report their planned expenditures for all behavioral health services and activities, not limited to only BHSA funded services and activities, other than those that are part of the Behavioral Health Care Continuum in Tab Two.

Rows 17 through 20: counties shall include their estimated total expenditures for the Integrated Plan period across all behavioral health funding sources and programs for each category listed. These costs are those that do not easily fit under the categories in Tab One, "BH CoC Expenditures."

Row 22: total projected expenditures will be auto-populated from rows 17 through 20.

For a list of all funding streams that should be included in the projected expenditures calculation for Table Two: Other County Expenditures please see the Behavioral Health Services Act County Policy Manual Chapter 3 Section A.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Two: Other County Expenditures

Other Expenditures	Total Projected Expenditures (Year One)	Total Projected Expenditures (Year Two)	Total Projected Expenditures (Year Three)
Capital Infrastructure Activities	$ 596,400.00	$ 55,000.00	$ 55,000.00
Workforce Investment Activities	$ 71,000.00	$ 57,000.00	$ 57,000.00
Quality & Accountability, Data Analytics, and Plan Management & Administrative Activities (including indirect administrative activities)	$ 1,525,350.00	$ 1,545,490.00	$ 1,589,725.00
Other County Behavioral Health Agency Services/Activities (e.g., Public Guardian, CARE Act, LPS Conservatorships, DSH for Housing, Court Diversion Programs)	$ 1,536,134.00	$ 1,536,134.00	$ 1,536,134.00
Total Projected Expenditures			
Total Projected Expenditures (auto-populated)	$ 3,728,884.00	$ 3,193,624.00	$ 3,237,859.00

Instructions

Counties shall report their planned revenue across the county behavioral health delivery system to support all behavioral health services and programs by funding source in Tab Three.

Rows 18 through 33: counties shall report projected expenditures for each funding source/program.

Row 21: for State General Fund, include funds received for the non-federal share of Medi-Cal payments.

Row 26: for Commercial Insurance (including Medicare), reporting reflects planned reimbursement obtained by county-operated providers, not county-contracted providers.

Row 35: total expenditures will be auto-populated from rows 18 through 33.

Row 36: will be auto-validated by DHCS against rows 35, 37, and 38. Validation: total projected expenditure variance should total out to $0.

Rows 37 and 38: will be auto-validated by DHCS against total projected expenditures in Tabs One and Two.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Three: Projected Annual Expenditures by County BH Funding Source

	Total Annual Projected Expenditures (Year One)	Total Annual Projected Expenditures (Year Two)	Total Annual Projected Expenditures (Year Three)
BHSA	$ 6,199,934.00	$ 6,275,935.00	$ 6,853,280.00
1991 Realignment (Bronzan-McCorquodale Act)	$ 2,191,439.00	$ 2,191,439.00	$ 2,191,439.00
2011 Realignment (Public Safety Realignment)	$ 132,056.00	$ 132,056.00	$ 132,056.00
State General Fund	$ 11,171,743.00	$ 11,171,743.00	$ 11,171,743.00
FFP (SMHS, DMC/DMC-ODS, NSMHS)	$ 1,540,138.00	$ 1,540,138.00	$ 1,540,138.00
Projects for Assistance in Transition from Homelessness (PATH)	$ 894,696.00	$ 894,696.00	$ 894,696.00
Community Mental Health Block Grant (MHBG)	$ 393,493.00	$ 393,493.00	$ 393,493.00
Substance Use Block Grant (SUBG)	$ 862,112.00	$ 862,112.00	$ 862,112.00
Commercial Insurance	$ 45,000.00	$ 45,000.00	$ 45,000.00
County General Fund	$ 25,944.00	$ 25,944.00	$ 25,944.00
Opioid Settlement Funds	$ 173,393.00	$ 173,393.00	$ 173,393.00
Other Funding Sources	**Total Annual Projected Expenditures (Year One)**	**Total Annual Projected Expenditures (Year Two)**	**Total Annual Projected Expenditures (Year Three)**
Other federal grants	$ -	$ -	$ -
Other state funding (including DSH funding)	$ 3,908,390.00	$ 3,908,390.00	$ 3,908,390.00
Other county mental health or SUD funding	$ 2,084,879.00	$ 2,131,862.00	$ 2,229,326.00
Other foundation funding	$ -	$ -	$ -
Summary	**Total Annual Projection (Year One)**	**Total Annual Projection (Year Two)**	**Total Annual Projection (Year Three)**
Total projected expenditures (all BH funding streams/ programs) (auto-populated)	$ 29,623,217.00	$ 29,746,201.00	$ 30,421,010.00
Total Projected Expenditure Variance	$	$ -	$ -
Auto-validation: Table 1: Behavioral Health Care Continuum Projected Expenditures	$ 25,894,333.00	$ 26,552,577.00	$ 27,183,151.00
Auto-validation: Table 2: Other County Expenditures	$ 3,728,884.00	$ 3,193,624.00	$ 3,237,859.00

Instructions

Counties shall report their base BHSA funding allocations, approved Housing Intervention Component Exemptions, and planned transfers on this sheet. **All counties must complete this sheet.**

Rows 38-40: input your county's base BHSA funding allocation by component and year.

Rows 43-54: this section will be auto-populated from the sections below it.

Rows 43, 49, and 53: the total adjusted allocation percentages for each component, inclusive of both exemptions and transfers.

Rows 44, 50, and 54: is the projected amount of funding, in dollars, based on the adjusted total allocation percentages.

Row 45: reflects the unspent MHSA funding that will be transferred to each of the Behavioral Health Services Act (BHSA) component allocations.

Row 46: reflects the excess prudent reserve funding that will be transferred to each of the BHSA components.

Rows 58, 80, and 102: the base funding amount for Housing Interventions will auto-populate from Column C, rows 38-40.

Rows 59, 81, and 103: if your county has an approved housing exemption, enter the percent of funds you are moving out of Housing Interventions into the other components. Enter this percentage as a positive value. It will automatically display as a negative value in the cell.

Rows 60, 82, and 104: if your county has an approved housing exemption, enter the percent of funds you are moving out of the other components and into Housing interventions. Enter this percentage as a positive value.

Rows 63, 85, 107: the base funding amount for Full Service Partnerships will auto-populate from Column D, rows 38-40.

Rows 68, 90, 112: the base funding amount for Behavioral Health Services and Supports will auto-populate from Column E, rows 38-40.

Rows 64, 69, 86, 91, 108, and 113: enter the percentage transferred out of Full Service Partnerships (FSP) and Behavioral Health Services and Supports (BHSS) into Housing Interventions, respectively.

Rows 65, 70, 87, 92, 109, and 114: enter the percentage transferred from Housing Interventions into Full Service Partnerships (FSP) and Behavioral Health Services and Supports (BHSS), respectively.

Rows 74, 96, 118: the updated base percentage will be auto-populated for Housing Interventions, FSP, and BHSS, respectively. Ensure the validation states "Row Equals 100%."

Rows 75, 97, 119: enter the amount you are transferring out of each component as a positive number. It will automatically display as a negative value. Ensure the validation states, "Row Does Not Exceed 14%."

Rows 76, 98, 120: enter the amount you are transferring into each component as a positive number. Ensure the validation states, "Transfers Out and In Equal."

Note: If your county plans to use Housing Intervention funds (up to 7 percent) to provide outreach and engagement, the amount of funds the county can transfer out of the Housing Intervention component (Row 75) must be decreased by the corresponding amount. Counties will document the amount dedicated to outreach and engagement in Tab 5. Housing Interventions.

Rows 77, 99, 121: the updated base percentage will be auto-populated for Housing Interventions, FSP, and BHSS, respectively. Ensure the validation states, "Row Equals 100%."

Rows 124-130: enter the amount of MHSA funds by component allocation transferring to each BHSA component. Encumbered unspent MHSA funds tied to WET, CFTN, or INN should be included; unencumbered INN funds should also be included. Please see Policy Manual Chapter 6, Section 7 for additional information.

Row 130: the total dollar amount of MHSA Transfers to BHSA is auto-populated.

Row 133: enter the dollar amount of prior year prudent reserve ending balance

Row 134: enter the prudent reserve maximum for your county.

Row 135: the dollar amount of excess prudent reserve funding to be transferred out of the prudent reserve will auto-populate. **Negative values indicate no transfer is necessary.**

Rows 136-138: enter the amount of excess prudent reserve funds allocated to each component.

Row 139: the total transferred excess prudent reserve is auto-populated.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Four: BHSA Transfers				
	County Base BHSA Funding Allocations Housing Intervention	County Base BHSA Funding Allocations Full-Service Partnership	County Base BHSA Funding Allocations Behavioral Health Services and Support	County Base BHSA Funding Allocations Total
Year One Component Allocation (dollars)	$ 1,697,562.00	$ 1,980,486.00	$ 2,521,886.00	$ 6,199,934.00
Year Two Component Allocation (dollars)	$ 1,882,781.00	$ 2,196,577.00	$ 2,196,577.00	$ 6,275,935.00
Year Three Component Allocation (dollars)	$ 2,055,984.00	$ 2,398,648.00	$ 2,398,648.00	$ 6,853,280.00
BHSA Transfers Year One Summary (auto-populated)				
	Housing Intervention	Full-Service Partnership	Behavioral Health Services and Support	Totals
Adjusted Total Allocation Percentages (Exemptions and Transfers)	10%	45%	45%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 565,854.00	$ 2,546,339.14	$ 3,242,424.86	$ 6,354,618.00
Unspent Mental Health Services Act (MHSA) to BHSA	$ -	$ 2,703,099.00	$ 1,667,400.00	$ 4,370,499.00
Excess Prudent Reserve (PR) to BHSA	$ -	$ -	$ -	$ -
BHSA Transfers Year Two Summary (auto-populated)				
	Housing Intervention	Full-Service Partnership	Behavioral Health Services and Support	Totals
Adjusted Total Allocation Percentages (Exemptions and Transfers)	10%	45%	45%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 627,593.67	$ 2,824,170.43	$ 2,824,170.43	$ 6,275,934.52
BHSA Transfers Year Three Summary (auto-populated)				
	Housing Intervention	Full-Service Partnership	Behavioral Health Services and Support	Totals
Adjusted Total Allocation Percentages (Exemptions and Transfers)	10%	45%	45%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 685,328.00	$ 3,083,976.00	$ 3,083,976.00	$ 6,853,280.00

Funding Transfer Request Allocations

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year One)		
Base Component (Year One)	**Housing Intervention Percentage (Year One)**	**Housing Intervention Funds (Year One)**
Base Percentage and Funding	30%	$ 1,697,562.00
Percentage Reduced	-20%	$ 1,131,708.00
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	10%	$ 565,854.00
Transferred To/From	**Full Service Partnership Percentage (Year One)**	**Full Service Partnership Funds (Year One)**
Base Percentage and Funding	35%	$ 1,980,486.00
Percentage Reduced	0%	$ -
Percentage Added	10%	$ 565,853.14
New FSP Base Percentage (auto-populated)	45%	$ 2,546,339.14
Transferred To/From	**Behavioral Health Services and Support Percentage (Year One)**	**Behavioral Health Services and Support Funding (Year One)**
Base Percentage and Funding	35%	$ 2,521,886.00
Percentage Reduced	0%	$ -
Percentage Added	10%	$ 720,538.86
New BHSS Base Percentage (auto-populated)	45%	$ 3,242,424.86

Funding Transfers (Year One)				
	Housing Intervention (Year One) (1)	Full-Service Partnership (Year One)	Behavioral Health Services and Support (Year One)	Validation
Base Percentage after Housing Intervention Component Exemption (auto-populated)	10%	45%	45%	Row Equals 100%
Amount Transferring Out	0%	0%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	0%	0%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	10%	45%	45%	Row Equals 100%

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year Two)		
Base Component (Year Two)	**Housing Intervention Percentage (Year Two)**	**Housing Intervention Funds (Year Two)**
Base Percentage and Funding	30%	$ 1,882,781.00
Percentage Reduced	-20%	$ 1,255,187.33
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	10%	$ 627,593.67
Transferred To/From	**Full Service Partnership Percentage (Year Two)**	**Full Service Partnership Funds (Year Two)**
Base Percentage and Funding	35%	$ 2,196,577.00
Percentage Reduced	0%	$ -
Percentage Added	10%	$ 627,593.43
New FSP Base Percentage (auto-populated)	45%	$ 2,824,170.43
Transferred To/From	**Behavioral Health Services and Support Percentage (Year Two)**	**Behavioral Health Services and Support Funding (Year Two)**
Base Percentage and Funding	35%	$ 2,196,577.00
Percentage Reduced	0%	$ -
Percentage Added	10%	$ 627,593.43
New BHSS Base Percentage (auto-populated)	45%	$ 2,824,170.43

Funding Transfers (Year Two)				
	Housing Intervention (Year Two) (1)	Full-Service Partnership (Year Two)	Behavioral Health Services and Support (Year Two)	Validation
Base Percentage after Housing Intervention Component Exemption (auto-populated)	10%	45%	45%	Row Equals 100%
Amount Transferring Out	0%	0%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	0%	0%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	10%	45%	45%	Row Equals 100%

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year Three)		
Base Component	**Housing Intervention Percentage (Year Three)**	**Housing Intervention Funds (Year Three)**
Base Percentage and Funding	30%	$ 2,055,984.00
Percentage Reduced	-20%	$ 1,370,656.00
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	10%	$ 685,328.00
Transferred To/From	**Full Service Partnership Percentage (Year Three)**	**Full Service Partnership Funds (Year Three)**
Base Percentage and Funding	35%	$ 2,398,648.00
Percentage Reduced	0%	$ -
Percentage Added	10%	$ 685,328.00
New FSP Base Percentage (auto-populated)	45%	$ 3,083,976.00
Transferred To/From	**Behavioral Health Services and Support Percentage (Year Three)**	**Behavioral Health Services and Support Funding (Year Three)**
Base Percentage and Funding	35%	$ 2,398,648.00
Percentage Reduced	0%	$ -
Percentage Added	10%	$ 685,328.00
New BHSS Base Percentage (auto-populated)	45%	$ 3,083,976.00

Funding Transfers (Year Three)				
	Housing Intervention (Year Three) (1)	Full-Service Partnership (Year Three)	Behavioral Health Services and Support (Year Three)	Validation
Base Percentage after Housing Intervention Component Exemption (auto-populated)	10%	45%	45%	Row Equals 100%
Amount Transferring Out	0%	0%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	0%	0%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	10%	45%	45%	Row Equals 100%

MHSA Transfers to BHSA				
MHSA Component	Available Unspent BHSA Funds	Transferred to Housing Intervention	Transferred to Full-Service Partnership	Transferred to Behavioral Health Services and Support
CSS	$ 1,242,955.00	$ -	$ 1,242,955.00	$ -
PEI	$ 2,460,144.00	$ -	$ 1,460,144.00	$ 1,000,000.00
Encumbered INN	$ -	$ -	$ -	$ -
Unencumbered INN	$ 541,400.00	$ -	$ -	$ 541,400.00
WET	$ 71,000.00			$ 71,000.00
CFTN	$ 55,000.00			$ 55,000.00
Total (auto-populated)	$ 4,370,499.00	$ -	$ 2,703,099.00	$ 1,667,400.00

Excess Prudent Reserve to BHSA Components	
Transfer from Prudent Reserve to BHSA Component Allocation	Amount
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$ 550,618.00
Local Prudent Reserve Maximum (2)	$ 1,397,657.11
Excess Prudent Reserve Funding that must be transferred	**$ (847,039.11)**
Housing Intervention (3)	$ -
FSP	$ -
BHSS (4)	$ -
Total Transferred Excess Prudent Reserve (auto-populated)	$ -

References

1. BHSA County Policy Manual section 6.B.5 states counties may use up to seven percent of Housing Interventions component funds on outreach and engagement. The amount of funds transferred out of the Housing Interventions component into another funding component must be decreased by a corresponding amount. Counties are not required to use Housing Intervention component funding for outreach and engagement, or other funding transfer requests. It remains at the discretion of the counties to transfer up to a total of 14 percent of its BHSA funds in a fiscal year.

2. W&I Code § 5892, subdivision (b)(3)-(4) states a county's prudent reserve must not exceed 20% of average of the total funds distributed to the county Behavioral Health Services Fund over past five years (25% for counties with a population of less than 200,000).

3. W&I Code § 5892, subdivision (b)(6)(B) states prudent reserve funding cannot be spent on capital development.

Instructions

Counties shall report their projected expenditures for their BHSA Housing Interventions allocation component. Counties shall report projected expenditures for all other non-BHSA funding sources in Tab Five.

Rows 39-42: input the estimated total Housing Intervention component allocation received for each year. Row 39 will auto-populate from Tab Four in the BHSA Transfers tab. Input unspent MHSA dollars carried over to this component into row 42. Row 43 will auto-populate-the sum of rows 40-42 to account for total funding.

Row 40: input the total dollar amount projected to be added to Housing Intervention component funds from the prudent reserve, if applicable. If you reported on Tab 4, row 136 that you will be transferring excess PR funds to Housing Interventions please report them here.

Rows 47-64: input the projected expenditures for each Housing Intervention component service category or program for each year.

Row 46: the aim of Housing Interventions is to help individuals achieve permanent housing stability. To the maximum extent possible, counties should seek to place individuals in permanent housing settings. Housing Interventions may only be used for placement in interim settings for a limited time, 6 months for BHSA eligible individuals who have exhausted the Transitional Rent benefit and 12 months for BHSA eligible individuals not eligible to receive Transitional Rent through their Medi-Cal MCP.

Row 51: pursuant to W&I Code section 5830, subdivision (c)(2), BHSA Housing Interventions may not be used for housing services covered by Medi-Cal Managed Care Plans (MCP). Please indicate the projected expenditures for BHSA funding ONLY in columns C, D, and E. Please indicate the projected expenditures for all other funding sources excluding BHSA in columns F, G, and H.

Row 63: input expenditures for BHSA-funded innovation pilots or projects.

Row 64: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub-allocations above.

Row 65: the sub-total will be auto-populated, excluding the percentage of rental and operating subsidies administered through Flex Pools.

Row 67: input the total dollar amount projected to be transferred out of Housing Intervention component funds into the prudent reserve.

Row 69 enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6. BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Costs).

Row 70: the overall total of Housing Intervention expenditures will be auto-populated-from rows 65, 67, and 69.

Row 72: input the total dollar amount for Housing Intervention component programs and services that will be dedicated to the chronically homeless population. This amount should equal 50% of Housing Interventions component allocation.

Row 73: input the total dollar amount for Housing Intervention component programs and services that will be dedicated to serving individuals with only a substance use disorder, if provided by the county. DHCS recognizes there may be duplication with funds captured in row 72.

Row 75: the proportion of funds dedicated to capital development will be auto-populated.

Row 76: the proportion of funds dedicated to the chronically homeless population will be auto-populated.

Row 77: the proportion of funds dedicated to Outreach and Engagement will be auto-populated.

Rows 79-80: input the estimated unduplicated count of individuals that will be served across all Housing Intervention component services.

Row 82: auto-populates projected estimated amount of MHSA Encumbered INN funds that will be available in the BHSA HI component for each year.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Five: BHSA Components						
	Total Housing Interventions Funding (Year One)	Total Housing Interventions Funding (Year Two)	Total Housing Interventions Funding (Year Three)			
Total Estimated Housing Intervention Funding Received (BHSA Funds)	$ 565,854.00	$ 627,593.00	$ 685,328.00			
Transfers into Housing Intervention component from Local Prudent Reserve	$ -	$ -	$ -			
Total Estimated Housing Intervention Funding Allocated (MHSA - Unspent Carryover Funds)	$ -	$ -	$ -			
Total Estimated Housing Intervention Funding (BHSA + MHSA Funds)	$ 565,854.00	$ 627,593.00	$ 685,328.00			
Housing Interventions Category						
Type of Service	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year One)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Two)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Three)	Projected Expenditures - All Other Funding Sources (Year One)	Projected Expenditures - All Other Funding Sources (Year Two)	Projected Expenditures - All Other Funding Sources (Year Three)
Housing Interventions Component Programs/Services						
Non-Time Limited Permanent Settings (e.g., supportive housing, apartments, single and multi-family homes, shared housing) (2)						
Rental Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
Operating Subsidies	$ 200,000.00	$ 200,000.00	$ 200,000.00	$ -	$ -	$ -
Bundled Rental and Operating Subsidies	$ 243,903.00	$ 285,062.00	$ 323,552.00	$ -	$ -	$ -
% of Rental and Operating Subsidies Administered through Flex Pools	0%	0%	0%	0%	0%	0%
Time Limited Interim Settings (e.g., hotel and motel stays, non-congregate interim housing models, recuperative care) (2)						
Rental Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
Bundled Rental and Operating Subsidies	$ 121,951.00	$ 142,531.00	$ 161,776.00	$ -	$ -	$ -
% of Rental and Operating Subsidies Administered through Flex Pools	0%	0%	0%	0%	0%	0%

Other Housing Interventions						
Other Housing Supports: Landlord Outreach and Mitigation Funds (2)	$ -	$ -	$ -	$ -	$ -	$ -
Other Housing Supports: Participant Assistant Funds (2)	$ -	$ -	$ -	$ -	$ -	$ -
Other Housing Supports: Housing Transition Navigation Services and Housing Tenancy Sustaining Services (2)	$ -	$ -	$ -	$ -	$ -	$ -
Other Housing Supports: Outreach and Engagement (2)	$ -	$ -	$ -	$ -	$ -	$ -
Capital Development Projects	$ -	$ -	$ -	$ -	$ -	$ -
Housing Flex Pool Expenditures (start-up expenditures)	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative Housing Intervention Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 565,854.00	$ 627,593.00	$ 685,328.00	$ -	$ -	$ -
Housing Interventions Transfer Information	**Year One**	**Year Two**	**Year Three**			
Transfers out of Housing Intervention component into Local Prudent Reserve (6)	$ -	$ -	$ -			
Housing Interventions Component Administrative Information	**Year One**	**Year Two**	**Year Three**			
Housing Interventions Component Admin Expenses	$ -	$ -	$ -			
Total Housing Interventions Expenditures (auto-populated)	$ 565,854.00	$ 627,593.00	$ 685,328.00			
Housing Interventions Populations to be Served	**Year One**	**Year Two**	**Year Three**			
Total Housing Interventions Component Funds Dedicated to Chronically Homeless Population (5)	$ 282,927.00	$ 313,797.00	$ 342,664.00			
Total Housing Interventions Component Funds Dedicated to Serving Individuals with a SUD only (5)	$ 141,463.00	$ 156,898.00	$ 171,332.00			

Housing Interventions Component Funds Validation (auto-populated based on inputs above)	Year One	Year Two	Year Three
Housing Intervention Component Funds Dedicated to Capital Development/Total Housing Interventions Funding (7) (auto-populated)	0.0%	0.0%	0.0%
Housing Interventions Component Funds Dedicated to Chronically Homeless Population/Total Housing Intervention Component Funding (8) (auto-populated)	50.0%	50.0%	50.0%
Housing Interventions Component Funds Used for Outreach and Engagement (2) (auto-populated)	0.0%	0.0%	0.0%
Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**
Eligible Children/TAY (25 years and younger)			
Eligible Adults/Older Adults	5	5	5
Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	**Year One**	**Year Two**	**Year Three**
MHSA "Encumbered" INN	$ -	$ -	$ -

References

1. W&I Code § 5892, subdivision (a)(1)(A)(i) states 30% of BHSA funds distributed to counties shall be used for Housing Interventions.

2. See Policy Manual Section 7.C.9 Allowable Expenditures and Related Requirements for further information regarding allowable Housing Interventions expenditures.

3. Single room occupancy and recovery housing can be interim or permanent. If interim, Housing Interventions is limited to 6 months for those who have exhausted Transitional Rent or 12 months for those not eligible for Transitional Rent. Appendix B of the Policy Manual includes a crosswalk of coverage by select programs.

4. Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls) and does not include behavioral health residential treatment settings.

5. Counties must provide Housing Intervention services to eligible children, youth, and adults (defined in W&I Code section 5892) who are chronically homeless, experiencing homelessness, or at risk of homelessness. The provision of BHSA-funded Housing Interventions specifically for individuals with a substance use disorder is optional for counties, per W&I Code section 5891, subdivision (a)(2).

6. W&I Code § 5892, subdivision (b)(2).

7. W&I Code § 5892, subdivision (a)(1)(A)(iii) states no more than 25% of Housing Interventions funds may be used for capital development.

8. W&I Code § 5892, subdivision (a)(1)(A)(ii) states 50% of Housing Interventions funds shall be used for housing interventions for persons who are chronically homeless, with a focus on those in encampments.

Instructions

Counties shall report their projected expenditures of their Full Service Partnership (FSP) funding for their BHSA allocation component, federal financial participation, and all other non-BHSA funding sources in Tab Six.

Rows 24-27: input the total estimated FSP component allocation received for each year. Row 24 will auto-populate from Tab Four in the BHSA Transfers tab.

Input unspent MHSA dollars carried over to this component into row 26. Row 27 will auto-populate the sum of rows 24-26 to account for total funding.

Row 26: input the total dollar amount projected to be added to FSP from the prudent reserve, if applicable. If you reported on Tab 4, row 137 that you will be transferring excess PR funds to FSP please report them here.

Rows 31-40: input the projected expenditures for each FSP service category or program for each year.

Note: DHCS expects other required uses of FSP funding (e.g., mental health services, supportive services, substance use disorder (SUD) treatment services, ongoing engagement services) to be captured within rows 31-36.

Any mental health and supportive service or SUD treatment service expenditures not included in these rows should be accounted for in rows 37-38, accordingly.

Row 39: input expenditures for BHSA-funded innovation pilots or projects.

Row 40: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub-allocations above.

Row 41: the subtotal of FSP programs/services will be auto-populated from rows 31-40.

Row 43: input the total dollar amount projected to be transferred out of FSP into the prudent reserve.

Row 45: enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6. BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Costs).

Row 46: total projected expenditures for FSP for each year will be auto-populated from rows 41, 43, and 45.

Rows 48 and 49: input the estimated unduplicated count of individuals that will be served across all FSP programs.

Row 51: auto-populates projected estimated amount of MHSA Encumbered INN funds that will be available in the BHSA FSP component for each year.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Six: BHSA Components

	Total Full Service Partnership (FSP) Funding (Year One)	Total Full Service Partnership (FSP) Funding (Year Two)	Total Full Service Partnership (FSP) Funding (Year Three)
Total Estimated Full Service Partnership Funding Received (BHSA Funds)	$ 2,546,339.00	$ 2,824,170.00	$ 3,083,976.00
Transfers into Full Service Partnership component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Full Service Partnership Funding Allocated (MHSA - Unspent Carryover Funds)	$ 2,703,099.00	$ 1,954,875.00	$ 1,755,640.00
Total Estimated Full Service Partnership Funding (BHSA + MHSA Funds)	$ 5,249,438.00	$ 4,779,045.00	$ 4,839,616.00

Full Service Partnership Category (1)									
Type of Service	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year One)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Two)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Three)	Projected Expenditures - Federal Financial Participation (Year One)	Projected Expenditures - Federal Financial Participation (Year Two)	Projected Expenditures - Federal Financial Participation (Year Three)	Projected Expenditures - All Other Funding Sources (Year One)	Projected Expenditures - All Other Funding Sources (Year Two)	Projected Expenditures - All Other Funding Sources (Year Three)
FSP Programs/Services									
Assertive Community Treatment (ACT)(2)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Forensic Assertive Community Treatment (FACT) Fidelity (2)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
FSP Intensive Case Management	$ 2,341,526.00	$ 1,907,026.00	$ 1,932,339.00	$ -	$ -	$ -	$ 1,509,105.00	$ 1,509,105.00	$ 1,509,105.00
High Fidelity Wraparound	$ 250,000.00	$ 250,000.00	$ 250,000.00	$ -	$ -	$ -	$ 250,000.00	$ 250,000.00	$ 250,000.00
Individual Placement and Support (IPS) Model of Supported Employment (2)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Assertive Field-Based Initiation for SUD Treatment Services	$ 332,519.00	$ 348,640.00	$ 359,919.00	$ -	$ -	$ -	$ -	$ -	$ -
Other mental health or supportive services not already captured above (e.g., outreach, other recovery-oriented services, peers, etc.): Please define	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other substance use disorder treatment services not already captured above (primary SUD FSP programs, innovation, etc.): Please define	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative FSP Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 2,924,045.00	$ 2,505,666.00	$ 2,542,258.00	$ -	$ -	$ -	$ 1,759,105.00	$ 1,759,105.00	$ 1,759,105.00

FSP Transfer Information	**Year One**	**Year Two**	**Year Three**
Transfers out of FSP component into Local Prudent Reserve	$ -	$ -	$ -
FSP Administrative Information	**Year One**	**Year Two**	**Year Three**
FSP Component Admin Expenses	$ 992,889.00	$ 1,018,533.00	$ 1,043,847.00
Total Full Service Partnership Expenditures (auto-populated)	$ 3,916,934.00	$ 3,524,199.00	$ 3,586,105.00
Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**
Eligible Children/TAY (25 years and younger)	70	70	70
Eligible Adults/Older Adults	1206	1206	1206
Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	**Year One**	**Year Two**	**Year Three**
MHSA "Encumbered" INN	$ -	$ -	$ -

References

1. W&I Code § 5892, subdivision (a)(2)(A) states 35% of BHS funds distributed to counties shall be used for Full Service Partnership Programs.
2. May be bundled or un-bundled depending on county BH-CONNECT opt-in.

Instructions

Counties shall report their projected expenditures of their Behavioral Health Services and Supports funding for their BHSA allocation component, federal financial participation, and all other non-BHSA funding sources in Tab Seven.

Row 26-29: input the total estimated BHSS component allocation received for each year. Row 26 will auto-populate from Tab Four in the BHSA Transfers tab.

Row 27: input the total dollar amount projected to the BHSS funding component from the prudent reserve (if applicable). If you reported on Tab 4, row 138 that you will be transferring excess PR funds to BHSS please report them here.

Input unspent MHSA dollars carried over to this component into row 28. Row 29 will auto-populate the sum of rows 26-28.

Rows 33-46: input the projected expenditures for each BHSS service category or program for each year. Rows 35, 39, and 42 auto-populate from their sub rows.

Row 45: input expenditures for BHSA-funded innovation pilots or projects.

Row 46: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub-allocations above.

Row 47: the subtotal for projected expenditures will be auto-populated from rows 33 - 35, 38, 39, 42, 45, and 46.

Row 49: input the total dollar amount projected to be transferred out of the BHSS funding component into the prudent reserve.

Row 51: enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6. BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Costs).

Row 52: the total for projected BHSS expenditures will be auto-populated from rows 47, 49, and 51.

Row 54: input the total dollar amount of Youth-Focused (25 years and younger) Early Intervention Expenditures.

Row 56: the proportion of EI funds will auto-populate from rows 29 and 35. Note: MHSA WET, INN, and CF/TN funds in Rows 65-67 will be deducted from the revenue (excluded from the denominator).

Row 57: the proportion of Youth-Focused (25 years and younger) EI funds will auto-populate from rows 35 and 54.

Rows 59-60: input the estimated unduplicated count of individuals that will be served across all BHSA-funded programs.

Rows 62-63: input the estimated amount of BHSS funds that will be transferred to WET and CF/TN for each year.

Rows 65-67: auto-populates projected estimated amount of MHSA WET, CF/TN, and Encumbered INN funds that will be available in the BHSA BHSS component for each year.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Seven: BHSA Components

	Total Behavioral Health Services and Supports (BHSS) Funding (Year One)	Total Behavioral Health Services and Supports (BHSS) Funding (Year Two)	Total Behavioral Health Services and Supports (BHSS) Funding (Year Three)
Total Estimated Behavioral Health Services and Support Funding Received (BHSA Funds)	$ 3,242,424.00	$ 2,824,170.00	$ 3,083,976.00
Transfers into Behavioral Health Services and Support component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Behavioral Health Services and Support Funding Allocated (MHSA - Unspent Carryover Funds)	$ 1,126,000.00	$ 1,100,000.00	$ 900,000.00
Total Estimated Behavioral Health Services and Support Funding (BHSA + MHSA Funds)	$ 4,368,424.00	$ 3,924,170.00	$ 3,983,976.00

Behavioral Health Services and Supports Category (1)									
Type of Service	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year One)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Two)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Three)	Projected Expenditures - Federal Financial Participation (Year One)	Projected Expenditures - Federal Financial Participation (Year Two)	Projected Expenditures - Federal Financial Participation (Year Three)	Projected Expenditures - All Other Funding Sources (Year One)	Projected Expenditures - All Other Funding Sources (Year Two)	Projected Expenditures - All Other Funding Sources (Year Three)
BHSS Programs/Services									
Children's System of Care-Non FSP (25 years and younger)	$ 820,281.00	$ 801,255.00	$ 801,408.00	$ -	$ -	$ -	$ 595,295.00	$ 595,295.00	$ 595,295.00
Adult and Older Adult System of Care, Excluding Populations Identified in 5892(a)(1) and 5892(a)(2)-Non FSP	$ 820,280.00	$ 801,255.00	$ 801,407.00	$ -	$ -	$ -	$ 595,294.00	$ 595,294.00	$ 595,294.00
Early Intervention Expenditures	$ 2,278,988.00	$ 2,120,430.00	$ 2,178,631.00	$ -	$ -	$ -	$ 1,850,362.00	$ 1,850,362.00	$ 1,850,362.00
Coordinated Specialty Care for First Episode Psychosis	$ 213,897.00	$ 221,098.00	$ 249,250.00	$ -	$ -	$ -	$ -		$ -
All Other EI Expenditures	$ 2,065,091.00	$ 1,899,332.00	$ 1,929,381.00	$ -	$ -	$ -	$ 1,850,362.00	$ 1,850,362.00	$ 1,850,362.00
Outreach and Engagement	$ 86,934.00	$ 89,230.00	$ 90,530.00	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Education and Training (WET)	$ 71,000.00	$ 57,000.00	$ 57,000.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated BHSA WET funds		$ 57,000.00	$ 57,000.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA WET funds	$ 71,000.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Capital Facilities and Technological Needs (CFTN)	$ 55,000.00	$ 55,000.00	$ 55,000.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated BHSA CF/TN funds		$ 55,000.00	$ 55,000.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA CF/TN funds	$ 55,000.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative BHSS Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 4,132,483.00	$ 3,924,170.00	$ 3,983,976.00	$ -	$ -	$ -	$ 3,040,951.00	$ 3,040,951.00	$ 3,040,951.00

BHSS Prudent Reserve Transfer Information	Year One	Year Two	Year Three
Transfers out of BHSS component into Local Prudent Reserve	$ -	$ -	$ -
BHSS Administrative Information	**Year One**	**Year Two**	**Year Three**
BHSS Component Admin Expenses	$ 157,567.00	$ 160,194.00	$ 162,819.00
Total Behavioral Health Services and Supports Expenditures (auto-populated)	$ 4,290,050.00	$ 4,084,364.00	$ 4,146,795.00
Youth-Focused Early Intervention Expenditures	**Year One**	**Year Two**	**Year Three**
Total Youth-Focused (25 years and younger) Early Intervention Expenditures	$ 1,162,284.00	$ 1,081,420.00	$ 1,111,102.00
Behavioral Health Services and Supports Validation (auto-populated based on inputs above)	**Year One**	**Year Two**	**Year Three**
BHSS Funds Early Intervention Expenditures/Total BHSS Funding (2)	53.7%	54.0%	54.7%
Youth-Focused (25 years and younger) Early Intervention Expenditures/Total Allocated Early Intervention Funds (3)	51.0%	51.0%	51.0%
Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**
Eligible Children/TAY (25 years and younger)	3424	3500	3554
Eligible Adults/Older Adults	3288	3350	3415
Projected BHSS Funds transferred to WET or CF/TN	**Year One**	**Year Two**	**Year Three**
BHSS transfer to WET		$ 57,000.00	$ 57,000.00
BHSS transfer to CF/TN	$ 2,596,400.00	$ 1,655,000.00	$ 155,000.00
Projected MHSA-Origin WET, CF/TN and Encumbered INN Funds Available (exempt from suballocation requirements)	**Year One**	**Year Two**	**Year Three**
Estimated MHSA WET Funds	$ 71,000.00	$ -	$ -
Estimated MHSA CF/TN Funds	$ 55,000.00	$ -	$ -
MHSA "Encumbered" INN	$ -	$ -	$ -

References
1. W&I Code § 5892, subdivision (a)(3)(A) states 35% of BHS funds distributed to counties shall be used for Behavioral Health Services and Supports (BHSS).
2. W&I Code § 5892, subdivision (a)(3)(B)(i) states counties shall utilize at least 51% of BHSS funding for early intervention programs.
3. W&I Code § 5892, subdivision (a)(3)(B)(ii) states that at least 51% of funds allocated for early intervention programs must serve individuals 25 years of age and younger.
4. BHSA Policy Manual Ch. 6 § B.7.3 states that MHSA WET or CFTN funds transferred into BHSA BHSS will remain WET or CFTN funds and will not be subject to the suballocation requirements. Counties may set aside BHSS funds for WET and CFTN; the reversion period for these specific funds is ten years. All transfers into WET and CFTN are irrevocable and cannot be transferred out of WET and CFTN. Counties may continue to keep separate fund accounts to track their WET and CFTN funds.
5. BHSA Policy Manual Ch. 6 § B.8.2.2 states that the share of indirect costs attributed to BHSA funding should be in proportion to the extent the BHSA program benefits from the support activity. Proportional administrative and indirect costs will be verified through the Behavioral Health Outcomes Accountability and Transparency Report (BHOATR). Counties should ensure that their cost-allocation methodology complies with 2 CFR 200 and appropriately distributes costs in proportion.

Instructions

Counties shall report their projected spending for Behavioral Health Services Act (BHSA) plan administration in Tab Eight.

Row 27: the total dollar-amount of BHSA component allocations dedicated to improvement and monitoring activities, including plan operations, quality and outcomes, data reporting pursuant to W&I Code § 5963.04, and monitoring of subcontractor compliance for all county behavioral health programs, including, but not limited to, programs administered by a Medi-Cal behavioral health delivery system, as defined in subdivision (i) of Section 14184.101, and programs funded by the Projects for Assistance in Transition from Homelessness grant, the Community Mental Health Services Block Grant, and other Substance Abuse and Mental Health Services Administration grants by year. Under W&I Code § 5892 (e)(2)(B), the total amount shall equal 2% or less of total projected annual revenues of the local behavioral health services fund for counties with a population over 200,000 or 4% of the total projected annual revenues of the local behavioral health services fund for counties with a population of less than 200,000. Any costs that exceed that amount will be included in the governor's budget. Administrative costs for improving and monitoring will only be reported on this tab, not the BHSA component tabs.

Row 28: input amounts of BHSA component allocations dedicated to county Integrated Plan annual planning costs, including stakeholder engagement in planning and local Behavioral Health Board activities by year. Under W&I Code § 5892 (e)(1)(B), this amount shall be 5% or less of total projected annual revenues of the local behavioral health services fund. Any costs that exceed that amount will be included in the governor's budget. Planning costs will only be reported on this tab, not the BHSA component tabs.

Row 29: input total dollar amount of new and ongoing county and behavioral health agency administrative costs to implement W&I Code § 5963-5963.06 and § 14197.71.

Row 30: select your county population size. This will ensure the formatting in the Admin Spending Overages section presents accurately.

Row 32: total projected annual revenues of the Local Behavioral Health Services Fund.

Row 33: the proportion of funding used for improvement and monitoring will be auto-populated from rows 32 and 27.

Row 34: the proportion of funding used for planning expenditures will be auto-populated from rows 28 and 32.

Row 36-38: based upon the county population size selected in row 31, this calculator will auto-populate any Improvement and Monitoring expenditures that exceed (2%/4%) of the total projected annual revenues of the Local Behavioral Health Services Fund and any County Integrated Plan Annual Planning expenditures that exceed 5% of the total projected annual revenues of the Local Behavioral Health Services Fund.

Table Eight: BHSA Plan Administration			
INTEGRATED PLAN ADMINISTRATION AND MONITORING	**Year One**	**Year Two**	**Year Three**
Total Projected Improvement and Monitoring Expenditures	$ 425,000.00	$ 430,000.00	$ 445,000.00
Total Projected County Integrated Plan Annual Planning Expenditures	$ 525,000.00	$ 530,000.00	$ 550,000.00
New and Ongoing Administrative Costs	$ 575,350.00	$ 585,490.00	$ 594,725.00
Select County Population Size:	Less than 200k		
Administrative Information Validation			
Total Projected Annual Revenues of Local Behavioral Health Services Fund	$ 10,708,900.00	$ 10,825,079.00	$ 11,140,653.00
Improvement and Monitoring Expenditures/Total Annual Revenues of Local Behavioral Health Services Fund (auto-populated)	4.0%	4.0%	4.0%
Total Projected Planning Expenditures/Total Projected Annual Revenues for Local Behavioral Health Services Fund (auto-populated)	4.9%	4.9%	4.9%
Admin Spending Overages (in Dollars)			
Improvement & Monitoring	$ -	$ -	$ -
Planning	$ -	$ -	$ -
Total	**$ -**	**$ -**	**$ -**
References			
1. W&I Code § 5963, subdivision (c) states that any costs incurred for BHSA implementation exceeding the required maximums set forth in W&I Code § 5892, subdivision (e)(1)(B) and W&I Code § 5892, subdivision (e)(2)(B) will be included in the Governors 2024-2025 May Revision.			

Instructions	
Counties shall report their estimated local prudent reserve maximums for each allocation component in Tab Nine.	
Rows 18-19: dollar amounts will be auto-populated from Tab 4 rows 133-134.	
Row 20: total excess prudent reserve dollars will be auto-populated from rows 18-19.	
Rows 21-23: total dollar amounts will be auto-populated from Tab 4, rows 136-138.	
Row 24: total excess prudent reserve funds allocated to BHSA components will be auto-populated from rows 21-23.	
Row 25: auto-validates from rows 20 and 24 to check if the county has "No Excess" or if county must "Reduce Excess" prudent reserve.	
Row 26: the total amount of planned contributions into the prudent reserve from all BHSA components allocations across all plan years will be auto-populated from Tab 5 row 67, Tab 6 row 43, and Tab 7 row 49.	
Row 27: the total amount of planned distributions from the prudent reserve into the BHSA component allocations across all plan years will be auto-populated from Tab 5 row 40, Tab 6 row 25, and Tab 7 row 27.	
Table Nine: Estimated Local Prudent Reserve Balance	
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$ 550,618.00
Local Prudent Reserve Maximum (1)	$ 1,397,657.11
Excess Prudent Reserve Funds (auto-populated)	$ (847,039.11)
Total prudent reserve funds above prudent reserve maximum allocated to Housing Interventions	$ -
Total prudent reserve funds above maximum allocated to Full Service Partnerships	$ -
Total prudent reserve funds above maximum allocated to Behavioral Health Services and Supports	$ -
Total Excess Prudent Reserve Funds allocated to BHSA Component Allocations (auto-populated)	$ -
Auto-validation: allocation of all excess Prudent Reserve Funds	NO EXCESS
Total Contributions Into the Local Prudent Reserve (auto-populated)	$ -
Total Distributions From the Local Prudent Reserve (auto-populated)	$ -
References	
1. W&I Code § 5892, subdivision (b)(3)-(4) states a county's prudent reserve must not exceed 20% of average of the total funds distributed to the county Behavioral Health Services Fund over past five years (25% for counties with a population of less than 200,000).	

Instructions

Counties will complete Tabs One through Nine prior to completing Tab Ten. Data on other tabs will auto-populate to Tab Ten.

Rows 25, 28, and 31: the new base percentage for each component will be auto-populated from Tab 4, rows 43, 49, and 53.

Rows 26, 29, and 32: the dollar amount allocated to each component for each year of the Integrated Plan will be auto-populated from Tab 5, row 39; Tab 6, row 24; and Tab 7, row 26, respectively.

Row 35: the total amount of BHSA funding for each component auto-populated from Tab 5, row 39; Tab 6, row 24; and Tab 7, row 26.

Rows 36, 44, and 52: the total amount of funding transferred from the prudent reserve into each BHSA component allocation for each plan year will be auto-populated from Tab 5, row 40; Tab 6, row 25; and Tab 7, row 27.

Row 37: the total amount of unspent MHSA-carryover funds from prior fiscal years, will be auto-populated from Tab 5, row 41; Tab 6, row 26; and Tab 7, row 28.

Rows 38, 46, and 54: estimated total available funding will be auto-populated from rows 35-37, 43-45 and 51-53.

Rows 39, 47, and 55: the total amount of funding transferred from each BHSA component into the prudent reserve for each plan year will be auto-populated from Tab 5, row 67; Tab 6, row 43; and Tab 7, row 49.

Rows 40, 48, and 56: estimated expenditures for each component will be auto-populated from Tab 5, row 70; Tab 6, row 46; and Tab 7, row 52.

Rows 45 and 53: auto-populated by adding the existing year's carryover MHSA funds to any remaining funds (from all sources) not spent from the previous year.

Rows 59-61: the total amount of annual BHSA plan administration expenses from Tab 8, rows 27-29.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Ten: BHSA Funding Summary (auto-populated)

	Housing Interventions	Full-Service Partnerships	Behavioral Health Services and Supports	Total
Year One				
Allocation Percentage, with Transfers	10%	45%	45%	100%
Component Allocations	$ 565,854.00	$ 2,546,339.00	$ 3,242,424.00	$ 6,354,617.00
Year Two				
Allocation Percentage, with Transfers	10%	45%	45%	100%
Component Allocations	$ 627,593.00	$ 2,824,170.00	$ 2,824,170.00	$ 6,275,933.00
Year Three				
Allocation Percentage, with Transfers	10%	45%	45%	100%
Component Allocations	$ 685,328.00	$ 3,083,976.00	$ 3,083,976.00	$ 6,853,280.00

BHSA Funding Summary (Year One)				
	Housing Interventions (Year One)	Full Service Partnerships (Year One)	Behavioral Health Services and Supports (Year One)	Year One Totals
Estimated Year One Component Allocations *(BHSA Funding Only)*	$ 565,854.00	$ 2,546,339.00	$ 3,242,424.00	$ 6,354,617.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds) *(Unspent Carryover MHSA Funds)*	$ -	$ 2,703,099.00	$ 1,126,000.00	$ 3,829,099.00
Estimated Total Available Funding for Year One	$ 565,854.00	$ 5,249,438.00	$ 4,368,424.00	$ 10,183,716.00
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year One Expenditures	$ 565,854.00	$ 3,916,934.00	$ 4,290,050.00	$ 8,772,838.00

BHSA Funding Summary (Year Two)				
	Housing Interventions (Year Two)	Full Service Partnerships (Year Two)	Behavioral Health Services and Supports (Year Two)	Year Two Totals
Estimated New Year Two Component Allocations *(BHSA Funding Only)*	$ 627,593.00	$ 2,824,170.00	$ 2,824,170.00	$ 6,275,933.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ -	$ 3,287,379.00	$ 1,178,374.00	$ 4,465,753.00
Estimated Total Available Funding for Year Two	$ 627,593.00	$ 6,111,549.00	$ 4,002,544.00	$ 10,741,686.00
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year Two Expenditures	$ 627,593.00	$ 3,524,199.00	$ 4,084,364.00	$ 8,236,156.00

BHSA Funding Summary (Year Three)				
	Housing Interventions (Year Three)	Full Service Partnerships (Year Three)	Behavioral Health Services and Supports (Year Three)	Year Three Totals
Estimated New Year Three Component Allocations *(BHSA Funding Only)*	$ 685,328.00	$ 3,083,976.00	$ 3,083,976.00	$ 6,853,280.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ -	$ 4,342,990.00	$ 818,180.00	$ 5,161,170.00
Estimated Total Available Funding for Year Three	$ 685,328.00	$ 7,426,966.00	$ 3,902,156.00	$ 12,014,450.00
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year Three Expenditures	$ 685,328.00	$ 3,586,105.00	$ 4,146,795.00	$ 8,418,228.00

BHSA Plan Admin Expenses				
Plan Admin Category	**Year One**	**Year Two**	**Year Three**	**Total**
Total Projected Improvement and Monitoring Expenditures	$ 425,000.00	$ 430,000.00	$ 445,000.00	$ 1,300,000.00
Total Projected County Integrated Plan Annual Planning Expenditures	$ 525,000.00	$ 530,000.00	$ 550,000.00	$ 1,605,000.00
Total Projected New and Ongoing Administrative Expenditures	$ 575,350.00	$ 585,490.00	$ 594,725.00	$ 1,755,565.00

Budget Template Updates			
Versio	Revision Dat	Description of Changes	Effective Date of Change
2.0	10/25/2025	Tab 10 (BHSA Summary): Formula updated to avoid double counting of MHSA unspent carryover funds.	10/25/2025
2.0	10/25/2025	Tab 7 (BHSS): EI Threshold calculation should exclude MHSA transferred WET and CFTN funds as they are exempt from suballocation requirements, formula revised to remove WET and CFTN. Added a BHSS transfer to WET/CFTN for reversion tracking.	10/25/2025
2.0	10/25/2025	Tab 8 (BHSA Plan Admin): Updated instructions to clarify DHCS will not pre-populate data for "Total Projected Annual Revenues of BHSF". Counties must enter in the data.	10/25/2025
2.0	10/25/2025	Tab 5, 6, 7 (BHSA Conponents): Added unspent MHSA funds row for year 1, 2 and 3.	10/25/2025
2.0	10/25/2025	Tab 7 (BHSS): Added separate rows for unspent MHSA WET/CFTN expenditures.	10/25/2025
2.0	10/25/2025	Tabs 1-10: Fixed formula and instruction errors	10/25/2025
3.0	2/18/2026	Tab 4 (BHSA Transfers): Added Year 2 and Year 3 for exemption requests	2/18/2026
3.0	2/18/2026	Tab 4 (BHSA Transfers): Added validation check for funding transfers	2/18/2026
3.0	2/18/2026	Tab 4 (BHSA Transfers): Added two new rows for unspent MHSA "Encumbered" INN Funds and unspent MHSA "Unencumbered" INN Funds.	2/18/2026
3.0	2/18/2026	Tab 5, 6 and 7 (BHSA Components): Moved transfers from prudent reserve into the BHSA component funding section to be included with total revenue	2/18/2026
3.0	2/18/2026	Tab 5, 6, and 7 (BHSA Components): Included prudent reserve transfers as an expenditure	2/18/2026
3.0	2/18/2026	Tab 5, 6, and 7 (BHSA Components): Included prudent reserve transfers as an expenditure	2/18/2026
3.0	2/18/2026	Tab 5, 6 and 7 (BHSA Components): Added a row for projected MHSA "Encumbered" INN Project expenditures.	2/18/2026
3.0	2/18/2026	Tab 5 (Housing Interventions): Removed projected encumbered MHSA INN fund expenditures from the 50% HI funds dedicated to chronically homeless suballocation requirement calculation.	2/18/2026
3.0	2/18/2026	Tab 7 (BHSS): Removed projected encumbered MHSA INN fund expenditures from the 51% BHSS funds dedicated to Early Intervention suballocation requirement calculation	2/18/2026
3.0	2/18/2026	Tab 8 (BHSA Plan Admin): Updated to include a validation check for "Improvement and Monitoring" (2% or 4%) and "Planning" (5%)	2/18/2026
3.0	2/18/2026	Tab 9 (Prudent Reserve Assessment): Updated PR validation checks to "No Excess" or "Reduce Excess"	2/18/2026
3.0	2/18/2026	Tab 10 (BHSA Summary): Included component percentage breakdowns for all three years	2/18/2026
3.0	2/18/2026	Tab 10 (BHSA Summary): Include total administrative and planning expenditures from tab 8	2/18/2026