ADMINISTRATIVE SERVICES DIVISION
1215 O Street, Suite 670
Sacramento, CA 95814

County Use of State Hospital Beds
Memorandum of Understanding

California Department of State Hospitals
and
The California Mental Health Services Authority (CalMHSA) and Participating Counties

I. RECITALS

A. The parties to this Memorandum of Understanding ("MOU") are the California Department of State Hospitals ("DSH"), the California Mental Health Services Authority ("CalMHSA") as administrative agent for participating Counties, and each participating County which has executed this MOU ("County") as indicated in Exhibit 1.

B. The DSH has jurisdiction over all DSH facilities, as defined in Welfare and Institutions Code, section 4100. For purposes of this agreement, the applicable facilities are only those identified in Welfare and Institutions Code, section 4100, subd. (a)-(e)

C. Welfare and Institutions Code section 4330 requires counties to reimburse DSH for the use of DSH Hospital beds and services, provided pursuant to the Lanterman-Petris-Short Act ("LPS", Welfare and Institutions Code section 5000 et. seq.) and in accordance with annual MOUs between DSH and each County acting singly or in combination with other counties, pursuant to Welfare and Institutions Code section 4331.

D. CalMHSA is a joint powers authority pursuant to Government Code section 6500 et seq. (Joint Exercise of Powers Act) whose members are counties and cities with mental health programs. CalMHSA negotiates the MOU with DSH on behalf of CalMHSA's members and serves as a liaison for matters of compliance with MOU terms and conditions.

E. DSH and CalMHSA agree that DSH beds represent the most restrictive, highest level of psychiatric care and therefore are intended to serve only those individuals whose clinical needs cannot be met in less intensive treatment settings. An LPS Patient's stay at DSH is intended to be temporary, with the length of stay

determined by the psychiatric needs of the individual. The parties agree that Patients should be discharged once they can be safely and appropriately treated in a lower level of care. Individuals with a primary medical diagnosis that is unrelated to the finding of grave disability should not be referred to DSH.

F. The terms and conditions herein remain subject to applicable court orders and statutes.

II. TERMS AND CONDITIONS

A. The term of this MOU is July 1, 2025 through June 30, 2027 ("FY 2025 – 2026, and 2026-2027"). The Intermediate Care Facility, Acute Psychiatric Hospital (APH) and Skilled Nursing Facility (SNF) bed rates agreed upon herein for FY 2025-26 and 2026-27 have an effective date of July 1, 2025, as identified in Exhibit 3. In accordance with the DSH authority outlined in Welfare and Institutions Code, section 4331, subd. (d), and the agreement reached with CalMHSA, implementation of the bed rates identified in Exhibit 3 shall commence July 1, 2025, even if individual counties have yet to fully execute the remainder of this agreement.

B. Admissions for Referred Patient ("Patient")

1. The County Mental Health Director, the County Behavioral Health Director, or their designee (collectively, "County Director") shall, in conjunction with the Public Guardian, as applicable, screen, determine the appropriateness of, and authorize all referrals for admission of Patients to DSH. The County Director shall, at the time of referral and admission, provide admission authorization and bed type to which a Patient is being referred, and identify the estimated length of stay for each Patient. This information shall be submitted electronically to the Patient Management Unit (PMU), and shall include a completed Face Sheet, Active Letters & Orders, and any other information as specified in the Bed Allocation Implementation Plan[1].

2. The County shall designate a point-of-contact who shall be empowered by the County to make determinations regarding the prioritization of referrals and serve as a county liaison regarding referrals, waitlist management, and admission coordination, as specified in the Bed Allocation Implementation Plan.

3. Upon receipt of a new referral, PMU will verify that the information provided meets the referral criteria specified in the Bed Allocation Implementation

[1] The Bed Allocation Implementation Plan is being developed by DSH in collaboration with CalMHSA and is hereby incorporated by reference. The implementation plan will be distributed to Counties upon its finalization as well available via SharePoint.

Plan and shall maintain a shared list with each county showing the county's verified referrals.

4. The County Director shall also name a County point-of-contact and provide assistance to the DSH clinical staff, in conjunction with the conservator and/or Public Guardian, in the screening of Patients to initiate, develop and finalize discharge planning and necessary follow-up services for the Patients. The County and DSH mutually agree that the goal is to transition Patients into their least restrictive setting, as clinically appropriate, as quickly as possible, and in alignment with Welfare and Institutions Code 5358. Either party may initiate this process by contacting the other party and the conservator and/or Public Guardian and engaging in collaborative discharge planning with the other party to ensure the patient's treatment needs are met.

C. Description of Provided Hospital Services

1. The DSH defines bed types and uses in accordance with the following California Department of Public Health hospital licensing definitions. These definitions shall apply to the MOU:

   a. Acute Psychiatric Hospital (APH) Acute psychiatric hospital means a hospital having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff which provides 24-hour inpatient care for mentally disordered, incompetent or other Patients referred to in Division 5 (commencing with section 5000) or Division 6 (commencing with section 6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy and dietary services. An acute psychiatric hospital shall not include separate buildings which are used exclusively to house personnel or provide activities not related to hospital patients.

   b. Intermediate Care Facility (ICF) Intermediate care facility is a health facility, or a distinct part of a hospital or skilled nursing facility which provides inpatient care to patients who have need for skilled nursing supervision and need supportive care, but do not require continuous nursing care.

   c. Skilled Nursing Facility (SNF) Skilled nursing facility is a health facility or a distinct part of a hospital which provides continuous skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. A skilled nursing facility provides 24-hour inpatient care and, at a minimum, includes physician, skilled nursing, dietary, pharmaceutical services and an activity program.

2. Provided the LPS Patient is admitted to a DSH hospital, as outlined in Welfare and Institutions Code, section 4100, subd. (a)-(e), DSH shall provide inpatient psychiatric health care and treatment, including outside medical health care

and treatment, ancillary care and treatment, and/or support services, to those persons admitted to DSH by the County or Public Guardian pursuant to Welfare and Institutions Code Section 5008, subdivision (h)(1)(A) (LPS Conservatorships) and/or subdivision (h)(1)(B) (Murphy Conservatorships). All DSH facilities that admit LPS patients shall comply with the responsibilities noted for DSH in this MOU. A summary of services provided to LPS Patients and the definition of care is detailed in Exhibit 2.

3. Upon receipt of appropriate notice, the DSH and the County shall provide or cause to be provided, witness testimony by appropriate mental health professionals in legal proceedings required for the commitment, admission, or treatment of the Patients.

4. The County is responsible for transportation to and from the Hospitals in the following circumstances: court appearances, County-initiated medical appointments or services, and pre-placement visits and discharge to final placements. The County is also responsible for transportation between Hospitals when the County initiates a request for transfer that is approved by DSH. The DSH is responsible for all DSH-initiated transportation between the Hospitals and transportation to and from local medical appointments or services. The reimbursement rates in Exhibit 3, entitled “Statement of Annual Bed Rates,” include reimbursement for transportation that is the responsibility of DSH.

5. Hospitals shall be culturally competent (including sign-language) in staff and resources and the overall milieu to meet the needs of Patients treated pursuant to this MOU.

6. Multi-disciplinary treatment team composition will be provided as set forth in Exhibit 2.

D. Pre-Admission, Admission, and Discharge Procedures

1. Admission will be offered based on bed availability in the manner prescribed by the LPS Bed Allocation Plan (Exhibit 5).

2. DSH shall maintain a list of the county order of admission and will notify counties of upcoming admission slots accordingly.

3. Once PMU notifies a county that there will be a bed available, the County has three (3) business days to inform PMU whether it intends to fill the bed, and which Patient from its verified referral list is the next priority admission. The County shall have no more than fourteen (14) calendar days from the date of the initial notification to provide a completed admission packet, as specified in the Bed Allocation Implementation Plan. If documentation is not received within fourteen (14) calendar days, the available bed will be offered to the next county, consistent with the Bed Allocation Plan (Exhibit 5). As part of the

admission packet, the County shall identify an initial projected length of stay which DSH shall address in Patient's treatment plan and discharge plan. All documentation will be provided to PMU via secure transfer utilizing WorkSpaces, SharePoint, or other successor application, as determined by DSH.

4. Hospital admissions, intra-hospital transfers, inter-hospital transfers, and referrals to outside medical care shall be determined by DSH.

5. All denials of admission by DSH shall be in writing with an explanation for the denial. Denial of admission may be based on the lack of the Patient's admission criteria/information identified in Section F of this MOU, or an inability to provide appropriate treatment based on Patient-specific treatment needs such as if a patient's primary treatment needs are medical. A denial of admission may be appealed as provided in the next paragraph.

6. Appeal Process for Admissions. If the County wishes to appeal a denial of admission, the case may be referred to the DSH Deputy Directors of Clinical Operations and Patient Care Coordination Division within five (5) business days. The DSH Deputy Directors of Clinical Operations and Patient Care Coordination shall discuss the case and shall obtain additional consultation from the County Director. The DSH shall render a final decision within five (5) business days after receiving the documented basis on which the appeal is based.

7. Discharge planning by the County Director, conservator and/or Public Guardian, and Hospital shall begin at admission, as individuals should be placed and receive services in the least restrictive setting appropriate for treatment. However, the estimated length of stay shall not be used as a basis for discharge.

8. The parties acknowledge the shared goal to transition individuals to the lowest level of care upon clinical readiness pursuant to the *Olmstead* decision.

9. The County agrees to share barriers to discharge and discharge planning information with DSH on a regular basis to facilitate timely discharge for patients meeting clinical criteria for discharge.

E. Bed Type Transfers

1. If, for any reason, a County Patient is in a bed that is inappropriate to that Patient's needs, the attending clinician shall develop, in consultation with the Hospital's treatment team, the County (except when the urgency of the Patient's situation precludes such consultation) and the conservator and/or Public Guardian, a plan for transfer of the Patient to an appropriate unit in accordance with the treatment plan. This plan shall be developed and communicated to the County Director and the conservator and/or Public

Guardian within forty-eight (48) hours of any urgent transfer. The County or conservator and/or Public Guardian may initiate a treatment team discussion with the attending Hospital clinician at any time the County or conservator and/or Public Guardian asserts that a County Patient is in a bed that is inappropriate to the Patient's needs or does not accurately reflect the level of care the Patient requires (APH, ICF, or SNF).

2. The Hospital shall provide the conservator and/or Public Guardian and County's Point-of-Contact notice of transfers between bed types within two (2) business days of any such transfer.

3. Bed Types Appeals. When agreement cannot be reached between the County staff and the Hospital staff regarding the type of bed the Patient needs, the following appeal process shall be followed. When the County staff feels that an impasse has been reached and further discussions would not be productive, the bed type may be appealed, along with all available data and analysis, to the Hospital Medical Director and the County Director, or designee, within two (2) business days. If the County Director and Hospital Medical Director are unable to achieve agreement, the case may be referred to the Hospital Executive Director and the County Director within two (2) business days. Such appeals may be made by telephone and shall be followed up in writing. If the Hospital Executive Director and the County Director are unable to achieve agreement, the case may be referred to the DSH Deputy Directors of Clinical Operations and Patient Care Coordination within two (2) business days. The DSH Deputy Directors of Clinical Operations and Patient Care Coordination shall discuss the case with the Hospital Medical Director and Executive Director and shall obtain additional consultation from the County Director, designee or the Public Guardian. The DSH shall render a final decision within two (2) business days after receiving the documented basis on which the appeal is based.

F. Coordination of Treatment/Case Management

1. It is the intent of the Parties to this MOU to be collaborative in all matters and specifically in matters of Patient care. Notwithstanding the independence of the Parties, all Patient services should be integrated and coordinated across levels of care for continuity of care.

2. The County shall maintain a case management process and shall identify a case manager or case management team for each Patient. The case manager shall provide available assessment information on Patients admitted to the Hospital.

3. The Hospitals shall provide at least two weeks notification to the County Director and conservator and/or Public Guardian of treatment plan conferences or 90-day reviews. The Hospitals shall identify a treatment team

member to function as the primary contact for the County case manager or the case management team.

4. The County Director, in conjunction with the conservator and/or Public Guardian, may direct the Hospital to discharge the Patient to a facility that the County determines to be more appropriate to the Patient's treatment requirements. The Hospital shall provide to the County Director, within five (5) business days of request for copies of current medical records, copies of current medical records needed to assist in this process. In such cases, the Hospital shall discharge the Patient within two (2) days of the date an alternative placement option is identified and available except if the discharge is contrary to the medical necessity of hospitalization or would pose an imminent danger to the safety of the Patient or others, or as otherwise required by law.

5. When an agreement cannot be reached between the County, the conservator and/or Public Guardian and the DSH on clinical assessment, treatment or the Patient's acuity, the DSH Hospital Medical Director or designee, the County Director or designee, and the conservator and/or Public Guardian shall confer for a resolution.

G. Patient's Rights and Confidentiality

1. The parties to this MOU shall comply with The Health Insurance Portability and Accountability Act (HIPAA) and all applicable state laws, regulations, and policies relating to the Patient's rights and confidentiality.

H. Bed Usage and Availability

1. Pursuant to Welfare & Institutions Code section 4331(a), DSH intends to make available a total of 581 beds for LPS patients at any one point in time. The intention of this bed total is to balance DSH's ability to provide services to LPS patients with DSH's obligations to admit patients committed pursuant to Penal Code sections 1026, 1370, and 2960 et. seq.

2. Consistent with the 2023-24 through 2024-25 MOU Sections H, CalMHSA and DSH agreed to a bed management protocol, informed by a bed allocation framework that considers factors including population, behavioral health population size, and historic bed utilization. This framework guides the allocation of DSH beds among counties and is used to determine the number of beds that may be assigned to each county. The resulting county-specific bed allocations and the associated protocol will be included as a written document agreed to by CalMHSA and DSH (Exhibit 5). Any changes to the protocol must be agreed to in writing by both parties.

3. If DSH intends to change LPS bed rates at the termination of this MOU's term, the following procedure shall apply:

a. No later than May 1 of the preceding fiscal year (i.e., May 1, 2026 for new rates intended to go into effect on July 1, 2027), DSH shall provide CalMHSA, or counties not represented by CalMHSA, with preliminary LPS bed rate cost utilization notice applicable to types of LPS beds for the fiscal year beginning fourteen (14) months from May 1 of that year. DSH shall provide CalMHSA, or counties not represented by CalMHSA, with preliminary cost and utilization information based on the best data possible, including the data compiled pursuant to Section J.2. below, to support the preliminary LPS bed rate.

b. After DSH's preliminary cost utilization notice, the County shall notify DSH through CalMHSA (if represented by CalMHSA), within two (2) months after receiving the data and information described in the preceding paragraph (i.e. by July 1), of its preliminary estimate of the number and type of LPS beds that the County expects to use, during the fiscal year beginning twelve (12) months from July 1 of that year, for bed planning purposes.

c. CalMHSA shall provide DSH with preliminary feedback related to the preliminary cost and utilization information based on the data provided by DSH by July 1 of that year.

d. No later than September 1 of that same fiscal year, DSH shall provide CalMHSA, or counties not represented by CalMHSA, with responses to the preliminary feedback provided by CalMHSA. The parties shall thereafter collaborate in good faith to resolve the outstanding questions.

e. No later than November 1 of that same fiscal year, DSH shall provide CalMHSA, or counties not represented by CalMHSA, with a proposed final LPS bed rate cost estimate based on the best data possible applicable to the number and types of LPS beds sought for the fiscal year beginning eight (8) months from November 1 of that year.

f. By January 1, CalMHSA, or counties not represented by CalMHSA, shall provide DSH with final written notification of the number and type(s) of LPS beds sought for the fiscal year beginning six (6) months from January 1 of that year. These notifications shall not preclude subsequent changes agreed to by both DSH and the county in the contract negotiation process.

g. DSH and CalMHSA shall negotiate in good faith to memorialize a formal agreement between CalMHSA, or counties not represented by CalMHSA, no later than May 15, or forty-six (46) days before the start of the fiscal year, with the new LPS bed rates and number of LPS beds contracted for.

h. Counties contracting directly with the DSH may submit the Statement of Annual Bed Rates and County Bed Need directly to the DSH. However, the County is only obligated to pay for beds it uses. The DSH will update Exhibit 3 with the County's bed need estimate and submit it to the County.

4. A County shall complete Exhibit 1 and provide a signed "Purchase Agreement of State Hospital Beds" (Exhibit 4) to DSH.

5. Patients under the care of the DSH, referred to outside medical facilities, will remain admitted to DSH unless the County, in conjunction with the conservator and/or Public Guardian, initiates discharge. Upon the completion of a County-initiated discharge, the Patient and all costs become the responsibility of the County.

6. During all offsite leaves, Counties will continue to be charged at the daily bed rate. For all offsite leaves of greater than thirty (30) days, the DSH and the County may, at the request of either party, and in conjunction with the conservator and/or Public Guardian discuss appropriate care options for Patients.

I. Bed Payment

1. The current bed rates are reflected in Exhibit 3.

2. The amount that the Controller is authorized to reimburse DSH from the mental health account of the County's Health and Welfare Trust Fund, pursuant to Welfare and Institutions Code section 17601, subdivision (b), is based on the amounts provided to the Controller per the County Actual Use statement reflecting actual bed usage by the County for the prior month.

3. The bed rates in this MOU represent the total amount due from the County for services provided in Section II, Terms and Conditions (C) (1-6, 7 (except for transportation for which a county is responsible), 8-9) by the DSH.

J. Records

1. Patient Records

a. Hospitals shall maintain adequate medical records on each Patient. These medical records shall include legal status, diagnosis, psychiatric evaluation, medical history, individual treatment plan, records of Patient interviews, progress notes, recommended continuing care plan, discharge summary, and records of services. These records shall be provided by various professional and paraprofessional personnel in sufficient detail to permit an evaluation of services.

b. Subject to applicable federal and California privacy laws and regulations, including DSH policies, the DSH will provide access to Patient medical records to Counties and CalMHSA through the use of a secure file sharing technology determined by the DSH. Access to the information described in this section shall only be made available to CalMHSA upon execution of a data sharing agreement. To facilitate such access, the DSH will work with CalMHSA and the Counties to make sure that each County has an authorized person with sufficient training and credentials (i.e., user name and password) that the person will be able to access DSH Patient records on behalf of the County.

c. Subject to applicable federal and California privacy laws and regulations, including DSH policies, upon request by the County for medical records of County's Patient, the DSH will ordinarily upload and make available to the County through a secure file sharing technology all current records of Patient within seven (7) business days, provided, however, that if records of a Patient are unusually voluminous the DSH may give notice that more than seven (7) business days will be needed.

d. Subject to applicable federal and California privacy laws and regulations, including DSH policies, upon request by the County for physical access to medical records of County's Patient, the DSH will make available all current records of Patient for inspection at the facility where Patient resides, within a timeframe agreed upon by the DSH Hospital representative and the County.

2. Financial Records

    a. The DSH shall prepare and maintain accurate and complete financial records of the Hospitals' operating expenses and revenue. Such records shall reflect the actual cost of the type of service for which payment is claimed, on an accrual basis. Any apportionment of, or distribution of costs, including indirect costs, to or between programs or cost centers of the Hospitals shall be documented, and shall be made in accordance with generally accepted accounting principles and applicable laws, regulations, and state policies. The Patient eligibility determination, and any fee charged to and collected from Patients, together with a record of all billings rendered and revenues received from any source, on behalf of Patients treated pursuant to this MOU, shall be reflected in the Hospital's financial records.

3. Retention of Records

    a. The Hospitals shall retain all financial and Patient records pursuant to federal, State and DSH record retention requirements.

K. Inspections and Audits

1. Consistent with confidentiality provisions of Welfare and Institutions Code section 5328, any authorized representative of the County shall have access to the medical and financial records of the DSH for the purpose of conducting any fiscal review or audit during the Hospital's record retention period. The Hospital shall provide the County adequate space to conduct such review or audit. The County may, at reasonable times, inspect or otherwise evaluate services provided in the Hospitals; however, the County shall not disrupt the regular operations of the Hospitals.

2. The County shall not duplicate reviews conducted by other agencies (e.g., State Department of Public Health, County Coroner's Office, and District Attorney's Office), if the detailed review results, methods, and work papers of any such review are made available to the County and the County determines the review was sufficient for County purposes. Practitioner-specific peer review information and information relating to staff discipline is confidential and shall not be made available.

L. Notices

1. Except as otherwise provided herein, all communication concerning this MOU shall be as follows:

Department of State Hospitals

trustoffice@dsh.ca.gov
(916) 654-2201

CalMHSA

Karleen Jakowski, LMFT
Senior Director, Cross County Contracts and Partnerships
managedcare@calmhsa.org
(279) 977-2752

The County has designated the following as its MOU coordinator:

Name: Emi Botzler- Rodgers
E-mail: mhbadmin@co.humboldt.ca.us
Phone: 707 268 2990

2. The Hospitals shall notify the County and the conservator and/or Public Guardian by telephone (with subsequent written confirmation), encrypted email or facsimile, within twenty-four (24) hours of becoming aware of any occurrence of a serious nature which involves a Patient. Such occurrences shall include, but are not limited to, homicide, suicide, accident, injury, battery, Patient abuse, rape, significant loss or damage to Patient property, and absence without leave.

3. The Hospital shall notify the County of the conversion of a Patient on LPS status to a PC commitment status that results in the DSH becoming financially responsible for the placement of the Patient. The Hospital shall notify the County, by telephone at the earliest possible time, but not later than five (5) business days after such conversion. Such telephone notification shall be followed by a written notification to the County, which shall be submitted no later than ten (10) business days after the Patient's conversion.

4. The Hospital shall notify the County of the conversion of a Patient on a PC commitment to LPS status that results in the County becoming financially responsible for the placement of the Patient. The Hospital shall notify the County, by telephone at the earliest possible time, but not later than five (5) business days after such conversion. Such telephone notification shall be followed by a written notification to the County, which shall be submitted no later than ten (10) business days after the Patient's conversion. Upon receipt of the DSH notification, the County shall provide a completed admission packet, as specified in the Bed Allocation Implementation Plan in the timeframe specified in Section D.3.

III. SPECIAL PROVISIONS

A. This MOU is subject to and is superseded by, any restrictions, limitations, or conditions enacted by the Legislature and contained in the Budget Act, or any statute or regulations enacted by the Legislature which may affect the provisions, terms, or funding of this MOU. The parties do not intend to amend or waive any statutory provision applicable to the use of state hospital beds by counties pursuant to Part 1 of Division 5 of the Welfare and Institutions Code, unless the subsection to be amended or waived is specifically identified in this MOU with a statement indicating the parties' intent to amend or waive the provision as thereinafter described. If statutory, regulatory, bed rate, or billing process changes occur during the term of this MOU, the parties may renegotiate the terms of this MOU affected by the statutory, regulatory, bed rate or billing process changes.

B. Should the DSH's ability to meet its obligations under the terms of this MOU be substantially impaired due to loss of a Hospital license, damage or malfunction of the Hospital, labor union strikes, or other cause beyond the control of the DSH, DSH has the discretion to immediately discontinue admissions and/or reduce the

number of beds available pursuant to the terms of this MOU. In such circumstances, DSH will notify the County as promptly as possible, collaborate with the County on any patient movement or arrangements, if necessary, and work to restore any impacted beds or treatment space.

C. Mutual Indemnification

1. The County shall defend, indemnify, and hold the DSH and its agencies, their respective officers, employees and agents, harmless from and against any and all liability, loss, expense, attorneys' fees, or claims for injury or damages arising out of the performance of this MOU but only in proportion to and to the extent such liability, loss, expense, attorneys' fees, or claims for injury or damages are caused by or result from the negligent or intentional acts or omissions of the County, its officers, agents, or employees.

2. The DSH shall defend, indemnify, and hold the County, its officers, employees, and agents, harmless from and against any and all liability, loss, expense, attorneys' fees, or claims for injury or damage arising out of the performance of this MOU but only in proportion to and to the extent such liability, loss, expense, attorneys' fees, or claims for injury or damages are caused by or result from the negligent or intentional acts or omissions of the DSH and/or its agencies, their officers, agents, or employees.

D. The signatories below represent that they have the authority to sign this MOU on behalf of their respective agencies. Execution by a participating County of Exhibit 1 confirms the participating County agrees to the terms of this MOU and Exhibits 1-5. This MOU and its Exhibit 1 may be executed in counterparts.

E. This MOU, which includes Exhibits 1-5 comprises the entire agreement and understanding of the parties and supersedes any prior agreement or understanding.

F. This MOU which includes Exhibits 1-5 may be amended or modified only by a written amendment signed by the parties.

G. The parties are independent agents. Nothing herein contained shall be construed as creating the relationship of employer and employee, or principal and agent, between the parties or any of their agents or employees.

_____ _____

Dr. Amie Miller, Executive Director
CalMHSA

Date

_____ _____

Dominique Williams, Chief
Business Management Branch
Department of State Hospitals

Date

EXHIBIT 1

Execution acknowledges the signatory possesses actual or apparent authority to declare the applicable County is a participating County under this MOU.

COUNTY OF HUMBOLDT:

Emi Botzler-Rodgers, Behavioral Health Director (*Pursuant to the Authority granted by the* Humboldt *County Board of Supervisors on June 24, 2025, 2025 [Item 25-816]*)	Date

EXHIBIT 2

LPS SERVICES SUMMARY

Licensure

The Hospitals comply with all applicable federal and state laws, licensing regulations and provide services in accordance with generally accepted practices and standards prevailing in the professional community at the time of treatment. The Hospitals, which are accredited, shall make a good-faith effort to remain accredited by the Joint Commission throughout the term of the MOU.

The DSH provides the services to its LPS patients as follows:

Core Treatment Team and Nursing Care

The Hospitals provide Treatment Team services that are the core to a Patient's stabilization and recovery. The Treatment Team groups consist of the following individuals: Psychiatrist, Psychologists, Social Workers, Rehabilitation Therapists, and Nurses. These teams provide a highly-structured treatment for mental rehabilitation and re-socialization in preparation for an open treatment setting or community placement.

Treatment Team Ratios		
Treatment Team Member:	ICF Staffing Ratio:	Acute Care Staffing Ratio:
Psychiatrist	1:35	1:15
Psychologist	1:35	1:15
Social Worker	1:35	1:15
Rehabilitation Therapist	1:35	1:15
Registered Nurse	1:35	1:15

The Hospitals provide nursing care according to nursing licensing ratio requirements for state hospitals as follows:

Licensing Compliance Nursing Staff Ratios (Non-Treatment Team)		
Nursing Shift:	ICF Staffing Ratio:	Acute Care Staffing Ratio:
A.M. Shift	1:8	1:6
P.M. Shift	1:8	1:6
NOC Shift	1:16	1:12

The ratios provided above are the current staffing standards employed by the DSH. Each facility may adjust unit ratios as necessary for the continued treatment and safety of Patients and staff.

Skilled Nursing Facility services provide continuous skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. A skilled nursing facility provides 24-hours inpatient care and, as a minimum, includes physician, skilled nursing, dietary, pharmaceutical services and an activity program.

Additional Treatment Services

Medical Services: Medical Clinics include Neurology, GYN, Ophthalmology, Optometry, Endocrinology, Cardiology, Podiatry, Dental and X-Ray services as well as referral services for Gastro-Intestinal care, Hematology, Nephrology, Surgery and related care for diseases of the liver (e.g., Hepatitis C). Full Acute Medical Care services are provided via contracts with community hospitals and/or a County Hospital.

Physical, Occupational and Speech Therapy (POST): Department provides physical rehabilitation services to all the patients at Napa State Hospital with the goal of assisting Patients to reach or maintain their highest level of functioning. The POST Team provides assessment services, treatment services and training to staff and Patients on the use and care of adaptive equipment that has been evaluated as appropriate for the Patient.

Individualized Active Recovery Services: Active Recovery Services focus on maximizing the functioning of persons with psychiatric disabilities and are provided both within the residential units and in the Treatment Mall. Treatment is geared to identify, support and build upon each person's strengths to achieve their maximum potential in meeting the person's hopes, dreams, treatment needs and life goals.

Active Recovery Services at the Hospitals:

- Are based on the specific needs of each Patient.
- Are developed and delivered based on a philosophy of recovery.
- Provide a wide range of courses and activities designed to help patients develop the knowledge and skills that support recovery, and transition toward community living.
- Are organized to fully utilize staff resources and expertise.
- Provide a range of services that lead to a more normalized environment outside of the residential areas.
- Are facilitated by psychiatrists, psychologists, social workers, rehabilitation therapy staff, and nursing staff.

Industrial Therapy: Opportunities include dining room cleaning services, grounds maintenance, as well as other therapeutic services. Participants must demonstrate an appropriate level of behavior to ensure safety and security.

EXHIBIT 3

COUNTY STATEMENT OF DAILY BED RATES
July 1, 2025 through June 30, 2027

1. STATE HOSPITAL BED RATE FOR FYs 2025-27

	FY 2025-26	FY 2026-27
Intermediate Care Facility (ICF)	765	792
Acute Psychiatric Hospital (APH)	790	818
Skilled Nursing Facility (SNF)	847	876

EXHIBIT 4

Purchase Agreement of State Hospital Beds

Fiscal Year 2025-26-2026-27

California Department of State Hospitals

By signing this Purchase Agreement, the County agrees to all recitals, terms and conditions, and special provisions between the County below and the Department of State Hospitals, (DSH) contained within the Fiscal Years (FY) 2025-26-2026-27 Memorandum of Understanding (MOU) for the purchase of state hospital beds from the DSH. The DSH shall be reimbursed for use of state hospital beds by counties pursuant to Welfare and Institutions Code section 4330 et seq. Any County signing this form will be entitled to the same services contained in the MOU. The County will also abide by the same remunerative and legal policies contained within the MOU. The County agrees to sign Exhibit 1 of the MOU within the next 120 days. The DSH reserves the right to not accept patients from any County without a signed Exhibit 1.

COUNTY OF HUMBOLDT:

_____

Emi Botzler-Rodgers, Behavioral Health Director (*Pursuant to the Authority granted by the Humboldt County Board of Supervisors on June 24, 2025 [Item 25-816]*)

_____

Date

Dominique Williams

_____

Chief, Business Management Branch– print

_____

Chief, Business Management Branch – sign/date

EXHIBIT 5

LPS Bed Allocation

Methodology

LPS bed allocations were developed using a county-specific methodology based on a combination of the following factors:

- **Population Size**: Calculated as the average of each county's share of the statewide census and Medi-Cal populations.
- **Behavioral Health Population Adjustment**: Indicators such as Point-in-Time (PIT) homeless counts, Homeless Management Information System (HMIS) utilization, County Health Rankings housing data, suicide rates, and opioid overdose rates were used to reflect behavioral health and housing needs.
- **Historical DSH Bed Utilization**: Based on actual census figures, waitlist data, and the number of individuals identified as ready for discharge from 2015 through 2024.

Counties were grouped into five allocation pools, determined by population size and corresponding bed need:

- **Small Rural** (counties receiving less than one bed each)
- **Small**
- **Medium**
- **Large**
- **Los Angeles County**

This methodology was designed to promote equitable distribution of LPS beds by accounting for both historical utilization and current population-based need and supports a transition to county self-management. The resulting allocation reflects a total of 581 LPS-designated beds for FY 2025-26, an increase of 25 beds compared to FY 2024-25. Allocations will be adjusted accordingly if the total number of available beds increases or decreases.

Fiscal Year 2025-26 LPS Bed Allocation

Pool	County	Allocation
Small Rural (<1)	Alpine	<1 per bed county (5 beds across 17 counties)
	Sierra	
	Inyo	
	Mariposa	
	Modoc	
	Mono	
	Colusa	
	Del Norte	
	Lassen	
	Trinity	
	Amador	
	Glenn	
	Plumas	
	Calaveras	
	Siskiyou	
	Tuolumne*	
	San Benito*	
Small	Tehama	1
	Nevada	1
	Mendocino	1
	Sutter	1
	El Dorado	1
	Yuba	1
	Lake	2
	Shasta	3
	Kings	3
	Madera	3
	Napa	4
	Humboldt	5

†

* For the purposes of this allocation protocol, counties marked with an asterisk are placed in a pool that differs from their traditional county size classification. This adjustment reflects admitting and waitlist trends that more closely align with the designated pool rather than their standard size category.