



LASSEN COUNTY

Health and Social Services Department

- ☐ **HSS Administration**
1345 Paul Bunyan Road, Ste B
Susanville, CA 96130
(530) 251 - 8128
- ☐ **Public Guardian/Administrator**
1345 Paul Bunyan Road, Ste B
Susanville, CA 96130
(530) 251 - 8337
- ☐ **Housing & Grants**
1445 Paul Bunyan Road, Ste B
Susanville, CA 96130
(530) 251 - 8309
- ☐ **Behavioral Health**
555 Hospital Lane
Susanville, CA 96130
(530) 251 - 8108
- ☐ **Public Health**
1445 Paul Bunyan Road, Ste B
Susanville, CA 96130
(530) 251 - 8183
- ☒ **Community Social Services**
1400 Chestnut Street, Ste A
Susanville, CA 96130
- LassenWORKS**
1616 Chestnut Street
Susanville, CA 96130
(530) 251 - 8152
- Child & Family Services**
1600 Chestnut Street
Susanville, CA 96130
(530) 251 - 8277
- Adult Services**
1400 Chestnut Street, Ste B
Susanville, CA 96130
(530) 251 - 8158
- Family Solutions/Wraparound**
1400 Chestnut Street, Ste C
Susanville, California 96130
(530) 251 - 8340

Mailing Address:
PO Box 1180
Susanville, California 96130

Date: June 9, 2026

To: Gary Bridges, Chairman
Lassen County Board of Supervisors

From: Jayson Vial, Agency Director
Lassen County Health and Social Services

Subject: Behavioral Health Services Act Integrated Three-Year Plan for Fiscal Years 2026-2027, 2027-2028, and 2028-2029

Background:

The Behavioral Health Services Act (BHSA), formerly known as the Mental Health Services Act (MHSA), requires counties to develop and adopt an Integrated Plan that outlines the use of BHSA funding to support behavioral health services and programs for county residents. The Integrated Plan serves as a comprehensive roadmap for addressing local behavioral health needs and ensuring compliance with state requirements.

The Fiscal Years 2026-2029 BHSA Integrated Plan was developed through a community planning process that included stakeholder engagement, public input, and collaboration with behavioral health partners, consumers, family members, services providers and community organizations. The planning process identified priority needs, service gaps, and opportunities to improve access to behavioral health services throughout Lassen County.

The Plan outlines proposed programs, services, and funding allocation that support prevention, early intervention, treatment services, workforce development, housing supports and other activities authorized under the BHSA framework. The Plan is designed to improve access to care, promote behavioral health equity, and support positive outcomes for individuals and families experiencing mental health and substance use challenges.

Fiscal Impact:

Programs and Services identified in the Plan will be funded through available Behavioral Health Services Act revenues and other eligible funding sources, subject to annual budget appropriators and state funding allocations.

Action Requested:

1) Approve the Behavioral Health Services Act Integrated Plan for Fiscal Years 2026-2027, 2027-2028, and 2028-2029, and 2) Authorize the Chairman to sign the Certification.

BEHAVIORAL HEALTH SERVICES ACT



INTEGRATED PLAN

FY 2026 - 2029

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

County, City, Joint Powers, or Joint Submission

County

Entity Name

Lassen County

Behavioral Health Agency Name

Lassen County Behavioral Health

Behavioral Health Agency Mailing Address

555 Hospital Lane, Susanville, CA 96130

Primary Mental Health Contact

Name : Tiffany Armstrong, LCSW

Email : TArmstrong@co.lassen.ca.us

Phone : 5302518108

Secondary Mental Health Contact

Name : Leslie Goni, LCSW

Email : LGoni@co.lassen.ca.us

Phone : 5302518108

Primary Substance Use Disorder Contact

Name : Tiffany Armstrong, LCSW

Email : TArmstrong@co.lassen.ca.us

Phone : 5302518108

Secondary Substance Use Disorder Contact

Name : N/A

Email : LCBH@co.lassen.ca.us

Phone : 5302518108

Primary Housing Interventions Contact (Optional. Enter if different from those listed above)

Name : N/A

Email : LCBH@co.lassen.ca.us

Phone : 5302518108

Compliance Officer for Specialty Mental Health Services (SMHS)

Name : N/A

Email : LCBH@co.lassen.ca.us

**Compliance Officer for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services
[For some counties the Compliance Officer names will be the same. No compliance officer for DMC State Plan is required.]**

Name : N/A

Email : N/A

Behavioral Health Services Act (BHSA) Coordinator (Minimum one contact required)

Name	Email Address
Andik Hidayat	AHidayat@co.lassen.ca.us

**Substance Abuse and Mental Health Services Administration (SAMHSA) liaison
(Minimum one contact required)**

Name	Email Address
Tiffany Armstrong, LCSW	TArmstrong@co.lassen.ca.us

Quality Assurance or Quality Improvement (QA/QI) lead (Minimum one contact required)

Name	Email Address
Tiffany Armstrong, LCSW	TArmstrong@co.lassen.ca.us

Medical Director (Minimum one contact required)

Name	Email Address
Dr. John Crowley	JCrowley@co.lassen.ca.us

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 (SMHS)	260
Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service	<11
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	<11
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	<11
Were chronically homeless or experiencing homelessness or at risk of homelessness	<11
Were in the juvenile justice system	<11
Have reentered the community from a youth correctional facility	<11
Were served by the Mental Health Plan and had an open child welfare case	29

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	<11
Have received acute psychiatric care	22

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	99
Received Medi-Cal SMHS	622
Received DMC or DMC-ODS services	148
Received MH and SUD services from the MHP and DMC county or DMC- ODS plan	137
Were chronically homeless, or experiencing homelessness, or at risk of homelessness	59
Experienced unsheltered homelessness	44
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	88
Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing	<11

Criteria	Number of Adults and Older Adults
Were in the justice system (on parole or probation and not currently incarcerated)	<11
Were incarcerated (including state prison and jail)	45
Reentered the community from state prison or county jail	45
Received acute psychiatric services	<11

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

a. Admitted or detained for 72-hour evaluation and treatment rate

67

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

12

c. 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?

No

Please describe the local data used during the planning process

LCBH uses multiple local data sources to inform the planning process, including data from its Electronic Health Record (EHR) to understand service utilization and client demographics. Lassen County jail booking data is also used to assess needs among justice-involved individuals.

Additional sources include prior Point-in-Time (PIT) Count data to understand homelessness trends, along with SacValley MedShare and Cal MHSA Dashboards for regional and statewide insights. Together, these data help guide data-driven planning and identify service gaps.

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

Local CARE Act Implementation

1. 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.

LCBH will support CARE participants through outpatient mental health services, SUD services, intensive outpatient services, case managements, intensive care coordination, and referral among community partners. LCBH will screen and assess to determine the medical necessity, and level of care. To ensure specialized coordination, LCBH will utilize multidisciplinary team, and collaborate closely with community partners (e.g., courts, hospitals, social services, housing services).

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

CARE referral and inquiry will be integrated into our EHR for monitoring and reporting.

3. 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.

LCBH will screen and assess potential eligible for CARE court and refer to outpatient services or community partners as necessary. LCBH will confirm and document the connection to services within our EHR.

County Behavioral Health Technical Infrastructure

Cities submitting their Integrated Plan independently from their counties do not have to complete this section.

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

Yes

Please select which of the following EHRs the county uses

Qualifacts Credible

Does the county behavioral health system participate in a Qualified Health Information Organization (QHIO)?

Yes

Please select which QHIO the county participates in [multi-select list]

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://www.lassencounty.org/dept/behavioral-health/health-information-systems-access>

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

Will the county participate in [SAMHSA's PATH Grant](#) during the Integrated Plan period?

No

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

No

Community Mental Health Services Block Grant (MHBG)

Will the county behavioral health system participate in any [MHBG](#) set-asides during the Integrated Plan period?

Yes

Please select all set asides that the county behavioral health system plans to participate in under the MHBG

Dual Diagnosis Set-Aside

Discretionary/Base Allocation

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

No

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

Will the county behavioral health system participate in any [SUBG](#) set asides during the Integrated Plan period?

Yes

Please select all set-asides that the county behavioral health system participates in under SUBG

Adolescent/Youth Set-Aside

Discretionary
Primary Prevention Set-Aside

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

No

Opioid Settlement Funds (OSF)

Will the county behavioral health system have planned expenditures for [OSF](#) during the Integrated Plan period?

No

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:

Not Applicable

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? [multi-select list]

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

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-ODS Program](#)

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

The county behavioral health system is mandated to provide the following services as a part of the [DMC-ODS Program](#) (DHCS currently follows the guidance set forth in the [American Society of Addiction Medicine \(ASAM\) Criteria, 3rd Edition](#)). (no action required)

- a. Care Coordination Services
- b. Clinician Consultation
- c. Outpatient Treatment Services (ASAM Level 1)
- d. Intensive Outpatient Treatment Services (ASAM Level 2.1)
- e. Medications for Addiction Treatment (MAT), Including Narcotics Treatment Program (NTP) Services
- f. [Mobile Crisis Services](#)
- g. Recovery Services
- h. Residential Treatment services (ASAM Levels 3.1, 3.3., 3.5)
- i. Traditional Healers and Natural Helpers
- j. Withdrawal Management Services
- k. All Other Medically Necessary Services for individuals under age 21
- l. Early Intervention for individuals under age 21

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

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.

DHCS – Behavioral Health Bridge Housing (BHBH) Program

LICN Housing – Medical Respite

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

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 to strengthen their evaluation and better understand community needs.

For related policy information, refer to [E.6.1 Population-level Behavioral Health Measures](#).

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

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?

a. For adults/older adults

Above

b. For children/youth

Above

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

Age

Race or Ethnicity

Spoken Language

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?

a. For adults/older adults

Above

b. 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?

a. For adults/older adults

Not Applicable

b. For children/youth

Not Applicable

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?

a. For adults/older adults

Below

b. For children/youth

Not Applicable

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

Age

Race or Ethnicity

Spoken Language

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?

Age

Race or Ethnicity

Spoken Language

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

For the previous fiscal year 2024-25, LCBH delivered 12,393 billable services. Those services were provided to 895 unique clients. Of those clients 96% identified as English speaking with the remainder identified as unknown or not reported. This is down 2.78 percentage points from the previous fiscal year. Given that the 2020 Census reports 18% of Lassen County residents speaking languages other than English at home, this finding points to a discrepancy between the MHP population served and the county population.

The majority of services were provided to female-identifying beneficiaries (For adults: 64% of all services were provided to females, 36% to males. For Youth: 48% of all services were provided to females, 52% to males. The degree of the majority stands in contrast with the demographic makeup of the LCBH beneficiary population, where 56% of adult beneficiaries (50.2% of youth beneficiaries) identify as female, 44% adults as male (49.8% of youth). This indicates a higher utilization for female than male beneficiaries. Those identifying as Other represented less than 1% of total services and further analysis cannot be published for reasons of ensuring confidentiality of a population under 15 individuals.

The racial and ethnic makeup of the beneficiary population is fairly representative of the Lassen County population with 78.9% of adult clients identifying (73.1% youth) as white (86.3% of all adult beneficiaries were non-Hispanic, 77.3% youth). The next largest racial minority is that of Native American and Black/African American (Both 3.2% of adult beneficiary population), with next ethnic minority being Mexican American / Chicano at 3.5% of adults and Other Hispanic/Latino at 8.8% of youth. According to 2020 Census data, Lassen County has a population of 20.3% Hispanic, and 1 % Native American. Compared to the beneficiary population it is clear that Native Americans make up of a heightened penetration rate while the penetration rate is significantly low for the Hispanic population.

Of the beneficiary population by race, The Native American-identifying population overutilized serves most as a percentage of their share of the client base – making up 3.2% of adult clients, but 3.6% of all adult services. This is in stark contrast to those reported as Black/African American who made up the same share of the beneficiary population (3.2%). However, this population only made up 1.2% of all adult services, demonstrating heightened underutilization. Compared with the white population who make up 78.9% of all adult clients, and 82.9% of all adult services.

The majority of beneficiaries served, and services provided, were to individuals aged 30-39 for adults (30% of all adult beneficiaries; 27.9% of all adult services), and aged 12-20 for youth (67.7% of all youth beneficiaries, 62.2% of all youth services). Of their populations, it is noted that the largest discrepancies in utilization can be found with those aged 0-11 and 12-20. Those aged 0-11 make of 32.3% of youth beneficiaries, but 37.8% of all youth services were provided to this population, averaging 19 services per person. This is in contrast with the population of 20-29, who make up 18.5% of all adults served) Those in this cohort make up only 16.5% of all services provided, averaging 10.5 services per person – the least number of services per person than any other age group. This finding indicates that while those aged 0-11 are receiving heightened care (as would be reflective in Intensive Service requirements for youth), those 20-29 are particularly underutilizing services.

What all these findings indicate is a need for LCBH to prioritize diversity and inclusion in practice and in outreach. It will be important to address why male-identifying beneficiaries are underutilizing total services but make up the largest share of Crisis encounters. It is a necessary and continuing goal of LCBH to increase penetration rates among the Hispanic, Asian, and non-English speaking populations through increased and culturally responsive outreach in order to be more reflective of the county population. And additionally, these findings indicate a need to prioritize increasing service utilization, not just increasing penetration rates, for young adults aged 20-29 and Black/African American identifying populations.

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)

Lassen County Behavioral Health (LCBH) continues to strengthen partnerships with Managed Care Plan (Partnership) and Local Health Jurisdiction to ensure clear referral pathways and improved access across the behavioral health continuum. The County will enhance outreach and engagement efforts to better meet the needs of underserved and high-risk populations and expand partnerships with community-based organizations to support access, linkages, and early intervention services using evidence-based and community-defined evidence-based practices. To improve data quality and equity monitoring, LCBH will train staff on accurate demographic data collection, including sexual orientation, gender identity, and language fields. The County will also work to strengthen early access pathways through collaboration with our MCP and community partners to reduce reliance on higher-acuity, crisis-driven entry points. Additionally, LCBH will regularly monitor and review data for trends and disparities to evaluate the effectiveness of proposed initiatives on continuous improvement.

Additionally, In 2026, LCBH is prioritizing contracting efforts with out of county providers to increase the scope of services provided to include day treatment and crisis stabilization.

Please identify the category or categories of funding that the county is using to address the access to care goal [multi-select dropdown]

- a. BHSA Behavioral Health Services and Supports (BHSS)
- b. BHSA Full Services Partnership (FSP)
- c. BHSA Housing Interventions
- d. 1991 Realignment

- e. 2011 Realignment
- f. Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS)
- g. Community Mental Health Block Grant (MHBG)
- h. Substance Use Block Grant (SUBG)

Homelessness

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?

Race or Ethnicity

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

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

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?

Above

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

Age

Gender

Race or Ethnicity

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?

Above

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

Age

Gender

Race or Ethnicity

Sex

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?

Below

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

Age

Gender

Race or Ethnicity

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

Based on the 2025 Point-in-Time Count, Lassen County reported 124 homeless individuals—64.5% sheltered, 35.5% unsheltered. Across the NorCal CoC region, significant disparities were identified: American Indian/Alaska Native individuals are overrepresented by 4.5 times and Black/African American individuals by nearly twice their general population share. Adults ages 35–44 comprise 24.2% of the homeless population but only 12.4% of the general population. Veterans make up 5.3% of homeless adults. Nearly half of unsheltered individuals are chronically homeless, and life expectancy is 20 years lower than housed individuals. While Lassen County's small homeless population limits statistically reliable subpopulation analysis, these regional disparities inform local priorities.

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)

Lassen County Behavioral Health continues to focus set of strategies to reduce homelessness among individuals with serious mental illness, serious substance use disorders, and co-occurring conditions, guided by data showing disproportionate outcomes for several demographic groups. The County will strengthen partnerships with Probation and local jail to create coordinated re-entry pathways along with integrating benefits reinstatement, housing navigation, and warm handoffs to reduce homelessness among individuals exiting custody. Collaboration with Medi-Cal

Managed Care Plan (Partnership) will be expanded to leverage Enhanced Care Management and Transitional Rent/Community Supports, improving care continuity and housing stability for individuals with complex needs. To increase local housing capacity, Lassen will invest Behavioral Health Services Act capital facility funds in low-barrier, clinically supportive housing, tailored for people with SMI and SUD. Continuous monitoring of disparities data will guide quality improvement, ensuring programs remain responsive to trends across age, race/ethnicity, gender, and service utilization. Ongoing engagement with individuals with lived experience and other key stakeholders will ensure that service delivery reflects local needs and supports populations with the most disparate outcomes.

Lassen County Behavioral Health is allocating BHSA Housing Interventions funds for time limited housing. BHBH-Behavioral Health Bridge Housing, a partnership with Lassen County Housing and Grant Department, will have 5 interim housing units. Unhoused individuals will initially fill the beds, for clients experiencing SMI, severe SUD, or co-occurring disorders. LCBH recently implemented bi-directional data exchange with Lassen County Housing and Grants to identify shared clients and provide linkage to housing resources.

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

BHSA BHSS

BHSA FSP

BHSA Housing Interventions

MHBG

SUBG

Other

Please describe other

BHBH and LICN (CMSP Grant)

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?

a. For adults/older adults

Not Applicable

b. For children/youth

Not Applicable

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

No Disparities Available

Institutionalization: Supplemental Measures

Involuntary Detention Rates, FY 2021 - 2022

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

a. 14-day involuntary detention rates per 10,000

Not Applicable

b. 30-day involuntary detention rates per 10,000

Not Applicable

c. 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?

a. Temporary Conservatorships

Not Applicable

b. Permanent Conservatorships

Not Applicable

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

Other

Please describe other

Small populations

SMHS Crisis Service Utilization (Crisis Intervention, Crisis Residential Treatment Services, and Crisis Stabilization) (DHCS), FY 2023

[Context text: Increasing access to crisis services may reduce or prevent unnecessary admissions to institutional facilities.]

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

a. Crisis Intervention

i. For adults/older adults

Below

ii. For children/youth

Below

b. Crisis Residential Treatment Services

i. For adults/older adults

Not Applicable

ii. For children/youth

Not Applicable

c. Crisis Stabilization

i. For adults/older adults

Not Applicable

ii. For children/youth

Not Applicable

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

No Disparities Data Available

Institutionalization: Disparities Analysis

1. 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 Available.

Institutionalization: Cross-Measure Questions

1. 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)

5150 inpatient

2. 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 county is implementing (e.g., enhancing crisis response services targeting a sub-population in which data demonstrates they have poorer outcomes)

Lassen County Behavioral Health will explore opportunities to expand increase collaboration with key partners to support field-based responses that divert individuals from involuntary holds and emergency departments. The County will also explore strategies to reduce reliance on involuntary detention, including expanding support for psychiatric advance directives. To address extended inpatient stays, the County will strengthen partnerships with housing programs to improve coordinated placement from inpatient and crisis settings and reduce administrative days. Coordination with Medi-Cal managed care plan (Partnership) and other stakeholders will be enhanced to increase utilization of community-based crisis services and reduce repeat emergency use. The County will also pursue opportunities for improved data sharing with key partners to support earlier identification of individuals who may benefit from community-based alternatives. Service utilization will continue to be monitored by demographic characteristics to identify disparities and guide targeted improvements aimed at reducing institutionalization across all population groups.

LCBH is currently working to implement day rehab program to offset crisis institutionalization. LCBH is coordinating with Lassen County Housing and Grants to reduce overutilization of hospital services.

3. Please identify the category or categories of funding that the county is using to address the institutionalization goal [multi-select dropdown]

BHSA BHSS

BHSA FSP

1991 Realignment

2011 Realignment

Federal Financial Participation (SMHS, DMC/DMC-ODS)

Justice-Involvement

Justice-Involvement: Primary Measures

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

1. How does your county status compare to the statewide rate/average?
 - a. For adults/older adults
 - Above
 - b. For juveniles
 - Below
2. What disparities did you identify across demographic groups or special populations?
 - Age
 - Gender
 - Race or Ethnicity
 - Sex

Justice-Involvement: Supplemental Measures

Adult Recidivism Conviction Rate (California Department of Corrections and Rehabilitation (CDCR)), FY 2019 - 2020

1. How does your county status compare to the statewide rate/average?
 - Above
2. 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.

1. How does your county status compare to the statewide rate/average?
Below
2. What disparities did you identify across demographic groups or special populations? No Disparities Data Available

Justice-Involvement: Disparities Analysis

1. 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

In analyzing the 45 individuals linked to Behavioral Health services and reported as booked in the Lassen County Jail during CY 2025, large disparity was found regarding Age, Sex/Gender, and race. Male identifying individuals accounted for 71% of all of the JI identified BH population – this is in large contrast to the population of services where only approximately 43% of unique clients served, identify as male as recorded in the Electronic Health Record. Approximately 31% of the JI beneficiaries were between the ages of 30-39 – this disparity is reflected in EHR data as this age range is also the most likely to be admitted to inpatient psych facilities (approx. 40% of all 5150 detainments in CY 2025 were for those aged 30-39). Racial disparities were also observed, with Black or Native American population accounted for 1G% of the BH JI population – this is in contrast to EHR records where the total population served by BH in CY 2025 was approximately 11% Black or Native American. Data on disparities amongst those experiencing recidivism is available put due to low population size cannot be reported

Justice-Involvement: Cross-Measure Questions

1. 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)

The County will strengthen a coordinated, data-driven strategy to reduce justice involvement among individuals with significant behavioral health needs by expanding Full-Service Partnership (FSP) capacity, integrating routine jail booking data, deepening collaboration with the Sheriff's Office and justice partners, and strengthening housing linkages. Local jail booking, emergency department, and crisis utilization data

demonstrate that individuals with serious mental illness, co-occurring substance use disorders, and housing instability experience poorer outcomes and higher rates of repeated justice involvement than the general behavioral health population, contributing to County performance below statewide medians in timely post-release treatment engagement and continuity of care. In response, the County will prioritize this sub-population for enhanced FSP enrollment, early identification through regular jail booking list review, and proactive discharge and diversion planning beginning within 24–48 hours of custody entry. LCBH is continuing to participate in the PATH grant, working with the jail and providing 90-day pre-release services to get individuals registered and assessed prior to release and schedule with behavioral health upon release. Multidisciplinary case coordination with the Sheriff’s Office, Probation, Courts, and behavioral health providers will support diversion opportunities, treatment engagement, and alternatives to incarceration, while housing navigation and supportive housing partnerships will address homelessness as a primary driver of recidivism. These initiatives are guided by local utilization trends and quality improvement review, and will be monitored through outcomes including jail bookings, length of stay, treatment engagement, housing stability, and re-arrest rates, with continuous refinement to ensure progress toward meeting or exceeding statewide benchmarks and improving long-term recovery-oriented outcomes.

The County will deepen collaboration with juvenile justice partners through regular case conferencing to support coordinated care planning for youth with behavioral health needs. Routine monitoring of arrest-related behavioral health data will guide continuous quality improvement and ensure disparities are actively identified and addressed. Lassen will strengthen partnerships with Managed Care Plans (Partnership) and other stakeholders to create more accessible and seamless pathways into mental health and substance use disorder services, thereby reducing avoidable law enforcement involvement for residents with behavioral health needs.

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

BHSA FSP

BHSA Housing Interventions

Federal Financial Participation (SMHS, DMC/DMC-ODS) MHBG

Removal of Children from Home

Removal of Children from Home: Primary Measures

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

1. How does your county status compare to the statewide rate?
Above
2. What disparities did you identify across demographic groups or special populations?
Gender

Removal of Children from Home: Supplemental Measures

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

1. How does your county status compare to the statewide rate?
Below
2. What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Child Maltreatment Substantiations (CWIP), 2022

1. How does your county status compare to the statewide rate?
Above
2. What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Removal of Children from Home: Disparities Analysis

1. 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 population in foster care, child welfare cases and CWIP in each category is below 15 individuals and disparities data would be subjected to a small sample bias

Removal of Children from Home: Cross-Measure Questions

1. 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 the removal of children from home. 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)

The County will explore additional opportunities to strengthen referral pathways for SMHS for children and youth involved in the child welfare system. Behavioral health services will continue to collaborate with Child Welfare to support immediate screening and linkage. The County will expand early intervention services in communities with higher substantiation rates and increase culturally and linguistically responsive family supports. To improve access for families with young children, the County will strengthen referral pathways for mental health and substance use treatment options for parents. Peer programs will also be expanded to offer interactive workshops for adults and families involved in the system that provide practical tools and exercises to support family resilience. The County will monitor access and removal trends by demographic characteristics on a regular basis to identify disparities and guide continuous quality improvement efforts.

Improve data tracking for intensive services eligibility and strengthen coordination with our county wraparound program and Family First Prevention Services Act (FFPSA) initiatives. This will enable us to more effectively address hospital care needs and work toward increasing parent participation in the parenting group.

Potential youth at risk of losing placement are immediately being referred to the Wraparound program.

2. Please identify the category or categories of funding that the county is using to address the removal of children from home goal [multi-select dropdown]

BHSA FSP

BHSA Housing Interventions

Federal Financial Participation (SMHS, DMC/DMC-ODS)

Untreated Behavioral Health Conditions

Untreated Behavioral Health Conditions: Primary Measures

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

1. How does your county status compare to the statewide rate/average?
 - a. For the full population measured

Below
2. 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

1. How does your county status compare to the statewide rate/average?
 - a. For the full population measured

Not Applicable
2. 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

1. How does your county status compare to the statewide rate/average?
 - a. For the full population measured

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

No Disparities Data Available

Untreated Behavioral Health Conditions: Disparities Analysis

1. 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

County is unable to provide disparities analysis for FUA and FUM as Numerators and Denominators are too low to report for these measures. For identifying those with untreated BH conditions, the county looks toward those reported to BH who were hospitalized for any BH condition and did not participate in follow-up services or had never entered and been registered with BH. For CY 2025, of all hospitalizations/5150s recorded, <15 individuals had never participated in BH service with LCBH. This number is subject to small sample bias, limiting the validity of any disparities analysis.

Untreated Behavioral Health Conditions: Cross-Measure Questions

1. Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026, that may decrease 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 county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

Beginning July 1, 2026, the county plans to strengthen partnerships with the local hospital and enhance coordination with the emergency department to better address untreated behavioral health conditions. LCBH will focus on assertive engagement in the community and collaboration with Lassen County Housing and Grants to engage those in need of housing supports. In 2026, LCBH is working to implement Enhanced Case Management (ECM) to help address untreated behavioral conditions.

2. Please identify the category or categories of funding that the county is using to address the untreated behavioral health conditions goal

BHSA FSP

BHSA Housing Interventions

Federal Financial Participation (SMHS DMC/DMC-ODS)

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

Care Experience: Primary Measures

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

1. How does your county status compare to the statewide rate/average?
 - a. For adults/older adults
 - Above
 - b. For children/youth
 - Above

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

1. How does your county compare to the statewide rate/average?
 - a. For adults/older adults
 - Not Applicable
 - b. For children/youth
 - Not Applicable

Engagement In School

Engagement in School: Primary Measures

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

1. 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

1. How does your county status compare to the statewide rate/average?
 - Above

Student Chronic Absenteeism Rate (Data Quest), 2022

1. How does your county status compare to the statewide rate/average?
 - Above

Engagement In Work

Engagement in Work: Primary Measures

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

1. 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

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

Overdoses

Overdoses: Primary Measures

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

1. How does your county status compare to the statewide rate/average?
 - a. For the full population measured
Above
 - b. For adults/older adults
Not Applicable
 - c. For children/youth
Not Applicable

Overdoses: Supplemental Measures

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

1. How does your county status compare to the statewide rate/average?
 - a. For the full population measured
Above
 - b. For adults/older adults
Not Applicable
 - c. For children/youth
Not Applicable

Prevention And Treatment of Co-Occurring Physical Health Conditions

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

1. How does your county status compare to the statewide rate/average?
 - a. For adults (specific to Adults' Access to Preventive/Ambulatory Health Service)
Below
 - b. 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

1. How does your county status compare to the statewide rate/average?
 - a. For adults/older adults (specific to Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications)
Below
 - b. For children/youth (specific to Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing)
Below

Quality Of Life

Quality of Life: Primary Measures

Perception of Functioning Domain Score (CPS), 2024

1. How does your county status compare to the statewide rate/average?
 - a. For the full population measured
Below
 - b. For adults/older adults
Above
 - c. For children/youth
Below

Quality of Life: Supplemental Measures

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

1. How does your county status compare to the statewide rate/average?
 - a. For the full population measured
Above

Social Connection

Social Connection: Primary Measures

Perception of Social Connectedness Domain Score (CPS), 2024

1. How does your county status compare to the statewide rate/average?
 - a. For the full population measured
Below

- b. For adults/older adults
Above
- c. For children/youth
Above

Social Connection: Supplemental Measures

Caring Adult Relationships at School (CHKS), 2023

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

Suicides

Suicides: Primary Measures

Suicide Deaths, 2022

1. How does your county status compare to the statewide rate/average?
 - a. For the full population measured
Not Applicable

Suicides: Supplemental Measures

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

1. How does your county status compare to the statewide rate/average?
 - a. For the full population measured
Above
 - b. For adults/older adults
Not Applicable
 - c. For children/youth
Not Applicable

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. [multi-select dropdown of statewide goals for improvement and reduction, excluding statewide priority goals] [logic: populate questions below for each goal selected]

1. **Goal #1** Overdoses

- a. Please describe why this goal was selected

Based on the survey and the stakeholder meetings, overdoses were selected by the community and there is a need of addressing the issue.

- b. 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.

Black males aged 45-49 disproportionally affected by overdose in Lassen County according to Cal MHSA overdose dashboard.

- c. 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 [selected goal] 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) [logic: auto-populate name of selected goal]

Leveraging our data exchange with MCP to access real time ADT data on individuals seen in the emergency room in SUD crisis and provide timely follow up.

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

Federal Financial Participation (SMHS, DMC/DMC-ODS)

Community Planning Process

Stakeholder Engagement

For related policy information, refer to [3.B.1 Stakeholder involvement](#)

1. Please indicate the type of [engagement used to obtain input](#) on the planning process
 - a. Survey participation
 - b. Training, education, and outreach related to community planning
2. Include date(s) of stakeholder engagement for each type of engagement

Type of engagement

Training, education, and outreach related to community planning

Date

2/24/2026

Type of engagement

Training, education, and outreach related to community planning

Date

2/26/2026

Type of engagement

Survey participation

Date

2/26/2026

Type of engagement

Training, education, and outreach related to community planning

Date

3/3/2026

Type of engagement

Survey participation

Date

3/3/2026

Type of engagement

Training, education, and outreach related to community planning

Date

3/5/2026

Type of engagement

Survey participation

Date

3/5/2026

Type of engagement

Training, education, and outreach related to community planning

Date

3/18/2026

Type of engagement

Survey participation

Date

3/18/2026

Type of engagement

Survey participation

Date

2/24/2026

3. Please list specific stakeholder organizations that were engaged in the planning process. Please do not include specific names of individuals. [narrative box]
 - a. For counties with a population greater than 200,000, what are the five most populous cities in the county (Cities submitting IP independently are not required to collaborate with other cities) ([Population and Housing Estimates for Cities, Counties, and the State](#)) (optional)

4. Were you able to engage [all required stakeholders/groups](#) in the planning process?

No

- a. If not, which required stakeholder/groups were you unable to engage in the planning process?

Area agencies on aging

Disability insurers

Health care service plans, including Medi-Cal managed care plans

Independent living centers

Labor representative organizations

Regional centers

- b. [Populate for each type of stakeholder group not engaged] What was the reason stakeholder was not engaged?

We sent the invitation through the BHSA Stakeholder Meetings flyer and shared the information on our website, social media, and a local online publication, but unfortunately, they did not attend the meetings.

5. 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

During the stakeholder meeting, key points regarding community needs and priorities in Lassen County were discussed. Both community members and partner organizations shared their perspectives, which were documented in meeting notes for reference. Additionally, we conducted a community survey to gather broader input. Based on the survey results, the community identified overdoses as an additional priority for the Integrated Plan, highlighting the need for targeted interventions in this area.

LCBH also conducted additional outreach to stakeholder groups that did not participate in the stakeholder meetings, including area agencies on aging, disability insurers, Medi-Cal managed care plans, independent living centers, labor organizations, and regional centers. These organizations were encouraged to complete the community survey to ensure their perspectives, identified service gaps, and recommendations were incorporated into the Integrated Plan development process. This outreach helped broaden community participation and ensured input was gathered from a diverse range of populations across Lassen County.

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](#).

1. 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.

2. 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

Lassen County Behavioral Health collaborated with Lassen County Public Health and Partnership in developing the Community Health Assessment (CHA). Lassen Public Health hired a contractor, Metopio, to lead the CHA process, which included facilitating community input sessions, focus groups, and convening local collaborators. Lassen County Behavioral Health participated at these sessions, ensuring our perspectives and data needs were incorporated. Through this collaboration, stakeholders were able to share data, provide input, and inform the development of CHA.

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

No

Collaboration

1. Please select how the county collaborated with the LHJ
Attended key CHA and CHIP meetings as requested.

Data-Sharing

Data-Sharing to Support the CHA/CHIP

1. Select Statewide Behavioral Health Goals that were identified for data-sharing to support behavioral health-related focus areas of the CHA and CHIP [multi-select list]
 - a. Access to Care
 - b. Homelessness
 - c. Suicides

2. Was data shared?

Yes

Data-Sharing from MCPS and LHJs to Support IP development

1. Select Statewide Behavioral Health Goals that were identified for data-sharing to inform IP development [multi-select list]

Access to Care

2. Was data shared?

Yes

Stakeholder Activities

1. 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 on joint surveys, focus groups, and/or interviews that can be used to inform both the IP and CHA/CHIP.

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

1. 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

Aligning stakeholders identified goals with the planning process of the IP and the Community Health Assessment (CHA).

Medi-Cal Managed Care Plan (MCP) Community Reinvestment

For related policy information, refer to [B.2 Considerations of Other Local Program Planning Processes](#).

1. Please list the Managed Care Plans (MCP) the county worked with to inform the MCPs' respective community reinvestment planning and decision-making processes
Partnership Health Plan
2. 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 MCP Community Reinvestment Plan aligns with needs identified through the Behavioral Health Services Act community planning process and the county's Integrated Plan by coordinating with Lassen County Public Health, Behavioral Health, and local partners.

Key needs were identified through the Community Health Assessment process, which included community input sessions, focus groups, and stakeholder engagement with Behavioral Health participation. Although the assessment is still pending full public release and Board approval, its findings are already guiding reinvestment priorities.

These efforts ensure MCP activities are aligned with emerging priorities such as improving behavioral health access, strengthening coordination, and supporting community-based services.

Comment Period and Public Hearing

For related policy information, refer to [B.3 Public Comment and Updates to the Integrated Plan](#).

1. Date the draft Integrated Plan (IP) was released for stakeholder comment
4/14/2026
2. Date the stakeholder comment period closed
5/14/2026

3. Date of behavioral health board public hearing on draft IP

6/9/2026

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

i. Link

<https://www.lassencounty.org/dept/behavioral-health/behavioral-health/current-news-and-information>

4. [Optional] 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

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

- a. Public posting

6. Please describe [stakeholder input](#) in the table below. Please add each stakeholder group into their own row in the table

Table 7. Stakeholder Input

Stakeholder group that provided feedback	Summarize the substantive revisions recommended this stakeholder during the comment period
TBD	TBD

7. 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.

TBD

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.

County Provider Monitoring and Oversight

Cities submitting their Integrated Plan independently from their counties do not have to complete the Medi-Cal Quality Improvement Plan questions or Question 1 under All BHSA Provider Locations. Otherwise, all fields must be completed unless marked as optional. For related policy information, refer to [6.C.2 Securing Medi-Cal Payment](#).

Medi-Cal Quality Improvement Plans

1. 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 [file upload]
2. 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

1. 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.)*

Table 8. Contracted BHSA Provider Locations Offering Non-Housing Services

Services Provided	Number of Contracted BHSA Provider Locations
Mental Health (MH) services only	0
Substance Use Disorder (SUD) services only	0
Both MH and SUD services	0

2. 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

Table 9. Contracted BHSA Provider Locations that Participate in Medi-Cal BHDS

Services Provided	Number of Contracted BHSA Provider Locations
SMHS only	0
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](#).

1. 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? *Note: DHCS will provide each county with a list of their SMHS providers that also contract with MCPs. Counties will then calculate a final percentage after excluding SMHS providers that do not offer any services that may be covered as NSMHS. 0%*
 - a. 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

N/A

2. 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.
 - i. Does the county wish to describe implementation challenges or concerns with these requirements?
No
3. 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:

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

Behavioral Health Services Act/Fund Programs

Behavioral Health Services and Supports (BHSS)

For related policy information, refer to [7.A.1 Behavioral Health Services and Supports Expenditure Guidelines](#)

General

1. Please select the specific [Behavioral Health Services and Supports \(BHSS\)](#) that are included in your plan
 - a. Children’s System of Care (non-Full Service Partnership (FSP))
 - b. Adult and Older Adult System of Care (non-FSP)
 - c. Early Intervention Programs (EIP)
 - d. Outreach and Engagement (O&E)
 - e. Workforce, Education and Training (WET)
 - f. Capital Facilities and Technological Needs (CFTN)

Children’s System of Care (Non-Full Service Partnership (FSP)) Program #1

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 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](#).

1. Please select the service types provided under Program
 - a. Mental health services
 - b. Supportive services
 - c. Substance Use Disorder treatment services

2. Please describe the specific services provided

LCBH provides services for Children's System of Care (Non-FSP) for mental health and substance use disorder services for eligible children and youth with moderate to severe behavioral health needs. The beneficiaries can walk into the office from Monday to Friday from 8 am to 5 pm to complete registration, assessment, and LCBH staff will determine the medical necessity and then it will be brought to the ACCESS Team meeting. Once a provider is assigned, the assigned provider will assess eligibility into intensive services and appropriate services that may include Outpatient, Therapy, targeted Case Management (TCM), Medication services, Substance use counseling, Housing assistance, Referral to Medicated-Assisted Treatment (MAT) services, Detox, Residentials Drug Medi-Cal Organized Delivery System (DMC-ODS), Day Rehab, Day Intensive, Therapeutic Behavioral Services (TBS), Crisis Stabilization, Child and Family Team (CFT), Intensive Home-Based Services (IHBS), Therapeutic Foster Care (TFC), and Intensive Care Coordination (ICC).

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

Table 10. Number of Individuals in the Children’s System of Care (Non-FSP) Served During the Plan Period by Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	260
FY 2027 – 2028	261
FY 2028 – 2029	262

4. Please describe any data or assumptions your county used to project the number of individuals served through the Children’s System of Care
- These projections were assumed based off the last full years of data captured in the current EHR. Identifying unique individuals served by Youth program over each year and calculating the percentage change year-over-year came to an average increase in Youth BH clients of .4% per year.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program #1

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](#).

1. Please select the service type provided under Program
 - a. Mental health services
 - b. Supportive services
 - c. Substance Use Disorder (SUD) treatment services

2. Please describe the specific services provided [narrative box]

LCBH provides services for Adult and Older Adult System of Care (Non-FSP) for mental health and substance use disorder services for eligible individuals with moderate to severe behavioral health needs. The beneficiaries can walk into the office from Monday to Friday from 8 to 5 to complete registration, assessment, and LCBH staff will determine the medical necessity and then it will be brought to the ACCESS Team meeting. Once a provider is assigned, the assigned provider will assess eligibility into intensive services and appropriate services that may include Outpatient, Therapy, Targeted Case Management (TCM), Medication services, Substance use counseling, Housing assistance, Referral to Medication-Assisted Treatment (MAT) services, Detox, Residentials Drug Medi-Cal Organized Delivery System (DMC-ODS), Day Rehab, Day Intensive, Therapeutic Behavioral Services (TBS), and crisis stabilization services.

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

Table 11. Number of Individuals in the Adult and Older Adult Systems of Care (Non-FSP) Served During the Plan Period by Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	589
FY 2027 – 2028	561
FY 2028 – 2029	534

1. 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

These projections were assumed based off the last full years of data captured in the current EHR. Identifying unique individuals served by Adult program over each year and calculating the percentage change year-over-year came to an average decrease in Adult BH clients of 4.8% per year.

Early Intervention Program #1

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](#).

1. Program or service name

Community Early Access and Support Strategy

2. Please select which of the three EI components are included as part of the program or service [multi-select list]

- a. Outreach
- b. Access and Linkage: Screenings
- c. Access and Linkage: Referrals
- d. Treatment Services and Supports: Services to address first episode psychosis (FEP)
- e. Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impact of suicide
- f. Treatment Services and Supports: Services to address co-occurring mental health and substance use issues
- g. Treatment Services and Supports: Other

Please specify “other” type of Treatment Services and Supports

- Suicide Prevention: an education program that educates community regarding signs and symptoms of suicide.
- Overdose Prevention: an education program that aims to reduce drug overdose deaths.
- Group NB – Nurturing/Parenting Group: an education group focuses on parents with substance use.
- Marijuana Group: an education group focuses on educating risks of marijuana uses.
- Whole Health Action Management (WHAM) Group: peer-led, science-based intervention designed to help individuals with chronic physical health conditions and behavioral health challenge.
- Medication Support Group for Medicare clients
- SUD Group for Non Medi-Cal recipients

3. 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

a. Please select the EBPs and CDEPs that apply

Nurturing Parenting Program (NP)

Dialectical Behavior Therapy

Drug counseling (individual and group)

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

Motivational Enhancement Therapy (MET) / Motivational Interviewing

Seeking Safety (SS)

Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

Please provide the name of the EBPs and CDEPs that apply

Friday Night Life (FNL) and BOTVIN

4. Please describe intended outcomes of the program or service

This strategy is intended to improve early identification, timely access, and successful linkage to mental health and substance use disorder services for BHSA-eligible high-risk individuals across priority populations, including older adults and youth. Through contracted providers implementing outreach, engagement, screening, navigation, and early intervention services, the initiative aims to increase awareness of behavioral health needs, reduce barriers related to culture, language, age, stigma, and system complexity, and strengthen connections to appropriate levels of care. By aligning services with DHCS BHSA policy requirements, the strategy seeks to ensure that individuals receive developmentally and culturally responsive supports early in the course of emerging behavioral health conditions. The intended outcomes include improved access and linkage metrics, reduced wait times to treatment initiation, increased engagement of underserved communities, stabilization of emerging symptoms, and prevention of escalation into more acute or crisis-level behavioral health needs.

5. 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

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

Table 12. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

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

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

County served approximately 2000 individuals under Prevention and Early Intervention in FY 24-25, the majority of individuals being reached through outreach events and community fairs.

Early Intervention (EI) Programs #2

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](#).

1. Program or service name

Early Childhood Services

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

Access and Linkage: Screenings

3. 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

- a. Please select the EBPs and CDEPs that apply

Nurturing Parenting Program (NP)

- b. Please provide the name of the EBPs and CDEPs that apply

Nurturing Parenting for Families in Substance Abuse Treatment and Recovery (SUD)

ABC's of Parenting (MH)

4. Please describe intended outcomes of the program or service

The program's primary goal is to promote healthy early development and reduce the long-term impacts of untreated developmental, behavioral, and social-emotional concerns among children ages birth to 5. Key strategies include providing parent and caregiver educational workshops using the DHCS-recommended evidence- parenting model, which is designed to strengthen positive parenting skills, increase caregiver

confidence, and reduce challenging behaviors in young children. In addition, the program conducts developmental and social-emotional screenings to identify children who may require further assessment, early intervention, or treatment services supporting earlier detection of needs and reducing the likelihood of escalation into more intensive behavioral health services later in childhood.

5. 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

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

Table 12. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	25
FY 2027 – 2028	25
FY 2028 – 2029	25

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

Data was pulled from group services entered into EHR for unique clients who attended nurturing parenting in calendar year 2025.

Early Intervention (EI) Programs #3

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.

1. Program or service name

School Based Behavioral Health Services

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

- a. Outreach
- b. Access and Linkage: Screenings
- c. Access and Linkage: Assessments
- d. Access and Linkage: Referrals
- e. Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impact of suicide
- f. Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

3. 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

4. Please describe intended outcomes of the program or service

Behavioral Health Services program serves children and youth in grades K-12 (up to age 21), providing early intervention behavioral health services at high need school sites across Lassen County as identified by participating school districts. The program aims to reduce the risk and severity of behavioral health crises by offering accessible, campus based supports that promote early identification and timely response to student needs. Services include mental health assessments and treatment provided by Behavioral health staff co-located at school campuses, enabling students to receive care in a familiar and low barrier setting. To maximize impact and reach underserved populations, the program prioritizes placing behavioral health staff at schools and sites with higher numbers of Medi-Cal eligible students. Through these efforts, the program supports improved student well-being, increased stability, and reduced escalation to higher level crisis services.

5. 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

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

Table 12. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	65
FY 2027 – 2028	70
FY 2028 – 2029	75

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

Data was pulled from services with a location indicating as provided at a school from the EHR for unique clients in calendar year 2025.

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](#).

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

- a. CSC program name

Early Psychosis Treatment Program

- b. CSC program description

The Early Psychosis Treatment Program, delivered by a community-based organization, offers comprehensive assessments and early intervention services using the evidence-based Coordinated Specialty Care (CSC) model for individuals ages 12–24 who are experiencing a first episode of psychosis or are exhibiting subthreshold symptoms. The intended outcome of this strategy is to promote early detection, provide timely and coordinated treatment, reduce the long-term impacts of psychosis, and improve overall recovery and functioning for young people and their families.

DHCS will provide counties with information to complete the estimated fields for eligible population and practitioners/teams needed for CSC. 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. These projections are not binding and are for planning purposes. In future guidance, DHCS will provide more information on the number of teams counties must implement to demonstrate compliance with BHSA CSC requirements.

2. 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.

Table 13. Estimated Number of Individuals Eligible for CSC and Estimated Number of Teams Needed to Serve Total Eligible Population

CSC Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	4
Number of Uninsured Individuals	0

CSC Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	4.25
Number of Teams Needed to Serve Total Eligible Population	1

3. 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-operated and 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.

Table 14. Total Number of CSC Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	4	4	4
Total Number of Teams	1	1	1

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

- a. Please list the other funding source(s)

Behavioral health delivery System, Medi-Cal, DMC-ODS

Outreach and Engagement (O&E) Program #1

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](#).

1. Program or activity name

Community Outreach and Engagement

2. Please describe the program or activity

The County Behavioral Health Outreach & Engagement Program expands access to behavioral health services by proactively identifying and engaging unserved and underserved community members in settings where they already feel safe and connected. Using BHSA BHSS funding, the program partners with a wide range of community organizations including schools, clinics, faith-based groups, cultural organizations, and local service providers to participate in or develop outreach opportunities tailored to community needs. Activities may include resource fairs, community events, informational sessions, and other engagement strategies that strengthen trust and awareness. Staff and peers provide culturally responsive information, education and informing materials, as well as nutritional and hydration support, and navigation support, offering warm linkages to the Access Line, treatment resources, and other community supports. The program is designed to reduce disparities and improve access to behavioral health services, while allowing flexibility to adapt outreach approaches as community needs and partnership opportunities evolve.

LCBH will engage Seriously Mentally Ill (SMI) individuals in the community for behavioral health support services. This project seeks to engage post-release adult and older adult offenders, homeless individuals/families, individuals with co-occurring issues who have been diagnosed with a severe mental illness or those who identify themselves as severely mentally ill by addressing barriers to service. This project also supports continued engagement in services as individual's transition into the community by providing seamless access to housing and BH support services at LCBH if such services are warranted. As identified through the community planning process, the SMI population in Lassen County is historically un- or underserved, at risk and faces many barriers to accessing services. Identified barriers include service location, housing, transportation, lack of benefits and service gaps. By providing psychiatric services at and linking participating individuals directly to BH services at LCBH, this project seeks to address barriers to service for this vulnerable population.

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

Table 15. Estimated Number of Individuals Served in O&E Programs by Plan Year

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

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

Data was estimated based of FY 2024/2025 outreach and engagement contact. The County estimated the number of individuals who may be reached through Outreach & Engagement (O&E) activities by drawing on prior years of outreach experience, typical engagement levels at community events, and anticipated staffing capacity. Historical patterns from resource fairs, school and clinic partnerships, and other community-based outreach efforts provide a reasonable basis for projecting annual reach.

County Workforce, Education, and Training (WET) Program #1

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](#).

1. Program or activity name

Internship Program

2. Please select which of the following categories the activity falls under

- a. Internship and Apprenticeship Programs

3. 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](#)

Workforce shortages and limited representation of diverse providers have historically created barriers to accessing care in Lassen County. In recent years, LCBH experienced vacancy rates of approximately 36% in difficult-to-fill direct service positions such as licensed clinicians and SUD counselors, limiting the County’s ability to meet growing service demand. To address these gaps, LCBH expanded its Behavioral Health Internship Program to “grow our own” workforce expanded partnerships with Chico and Humboldt State universities, and introduced paid internships, practicums, and licensure-hour opportunities to reduce financial barriers that often limit participation by students from underrepresented communities.

County Workforce, Education, and Training (WET) Program #2

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](#).

1. Program or activity name

Training

2. Please select which of the following categories the activity falls under
 - a. Workforce recruitment, development, Training, and Retention
3. Please describe efforts to address disparities in the Behavioral Health workforce. Additional information regarding diversity of the behavioral health workforce can be found in [Policy Manual Chapter 7, Section A.4.9](#)

LCBH training efforts focus on building a more diverse and culturally responsive behavioral health workforce. Trainings are designed to increase cultural humility, understanding the culture of frontier communities, and support the professional development of staff and peers from a wide range of racial, ethnic, geographic, and lived-experience backgrounds. These activities help ensure our workforce is better equipped to meet the needs of the diverse communities we serve. Many of the staff hired from Universities do not have the basic skills in understanding trauma informed care or evidence-based practices that are now required elements working for a County Behavioral Health Department.

County Workforce, Education, and Training (WET) Program #3

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](#).

1. Program or activity name

Reimbursement for License Renewal

2. Please select which of the following categories the activity falls under
 - a. Professional Licensing and/ or Certification Testing and fees

3. Please describe efforts to address disparities in the Behavioral Health workforce.

Additional information regarding diversity of the behavioral health workforce can be found in [Policy Manual Chapter 7, Section A.4.9](#)

LCBH offers reimbursement for professional license renewal fees to help retain a diverse behavioral health workforce. By reducing financial barriers for staff from different racial, ethnic, linguistic, and geographic backgrounds—including individuals with lived experience—this support promotes stability and diversity across the workforce.

Capital Facilities and Technological Needs (CFTN) Program #1

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](#).

1. Project name

Electronic Health Record

2. Please select the type of project

- a. Technological needs project

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

- a. Data exchange and interoperability

- b. Data security and privacy

- c. Data warehouse

3. Please describe the project

Electronic Health Record current vendor will support the interoperability functions and full level of care tool development including a customizable data collection and business intelligence platform that facilitates ease of data collection and converts data into real time outcomes monitoring infographics and 'next best actions' for individuals and populations. The data collection tool allows Behavioral Health to create easy to use data visuals around programs and client care, support shared decision-making between staff and clients, reduce burden on staff utilizing spreadsheets, standardizing outputs and metrics tracked, inform contracts and outcome expectations, and meet compliance requirements for the state.

Full Service Partnership Program

[Context text: 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](#)]

1. 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

Table 16. Estimated Number of Individuals Eligible for Full Service Partnership Services

Total Adult FSP Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	72
Number of Uninsured Individuals	8
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	28

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

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

Table 17. Estimated Number of Individuals Eligible for ACT

ACT Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	10
Number of Uninsured Individuals	1

Table 18. Estimated Number of Individuals Eligible for FACT

FACT Eligible Population (ACT with Justice-System Involvement)	Estimates
Number of Medi-Cal Enrolled Individuals	5
Number of Uninsured Individuals	1

Table 19. Estimated Number of Teams Needed to Serve Total Eligible Population

ACT/FACT Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	10
Number of Teams Needed to Serve Total Eligible Population	1

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 Full-Time Equivalents (FTEs) (county-operated and 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.

Table 20. Total Number of ACT and FACT Practitioners and Teams

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

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

Table 21. Estimated Number of Individuals Eligible for FSP ICM and Estimated Number of Teams Needed to Serve Total Eligible Population

FSP ICM Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	23
Number of Uninsured Individuals	3
FSP ICM Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	5
Number of Teams Needed to Serve Total Eligible Population	1

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-operated and 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.

Table 20. Total Number of FSP ICM Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	5	5	5
Total Number of Teams	1	1	1

High Fidelity Wraparound (HFW) Eligible Population

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

Note: HFW guidance is forthcoming; DHCS will provide these estimates in accordance with HFW guidance.

Table 23. Estimated Number of Individuals Eligible for HFW and Estimated Number of Teams Needed to Serve Total Eligible Population

HFW Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	40
Number of Uninsured Individuals	4
HFW Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	5
Number of Teams Needed to Serve Total Eligible Population	1

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-operated and 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.

Table 24. Total Number of HFW Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	5	5	5
Total Number of Teams	1	1	1

Individual Placement and Support (IPS) Eligible Population

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

Table 25. Estimated Number of Individuals Eligible for IPS and Estimated Number of Teams Needed to Serve Total Eligible Population

IPS Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	102
Number of Uninsured Individuals	11

IPS Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	7.5
Number of Teams Needed to Serve Total Eligible Population	3

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-operated and 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.

Table 24. Total Number of IPS Practitioners and Teams

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

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

Yes

- a. Please describe how the estimated practitioners will provide more than one EBP

Due to Lassen County's small size and small staff, LCBH does not have the resources to devote dedicated teams. All therapists, prescribers, and case managers will be responsible for providing applicable EBPs for their caseloads, which may contain clients eligible for FSP ICM, HFW, IPS, or CSC.

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

Consistent staff training ensures that trauma-informed principles are integrated into all services. LCBH's workforce is trained regularly on trauma informed approaches including whole person care and supporting natural supports. Peer Support Specialists are also embedded in FSP programs which also leverages lived experiences that are utilized to help support individuals and families served. Identified natural supports are also included in treatment which is inclusive of family members/identified support person and rendering services in natural environments.

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

LCBH works to reduce disparities among FSP participants by using data to identify gaps in access, engagement, and outcomes across populations and adjusting outreach and service delivery as needed. Services are provided based on individual need and include flexible engagement strategies, care coordination, and linkage to housing, medical, and social supports to reduce barriers to participation. LCBH coordinates with partner agencies and community providers to improve access for underserved populations and promote equitable service delivery within available resources.

The county promotes accessibility through FSP (both adults and Transitional Age youth) intensive wraparound program addressing housing instability, justice involvement, trauma, and substance use. These efforts are reinforced by continuous quality improvement aligned with CalAIM standards, underscoring Lassen County's commitment to equitable, culturally competent mental health services for all FSP participants.

All FSP teams work to maintain culturally and linguistically responsive office environments, including the use of culturally reflective signage, posters, and cultural recognition displays. Staffing across programs emphasizes cultural and linguistic diversity. Teams utilize flex funds to help families meet essential needs, collaborate with housing programs to promote long-term stability, and meet clients in community settings to reduce barriers and ensure accessible, youth-centered support.

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

Homelessness

Institutionalization

Access to care

Justice involvement

Untreated behavioral health conditions

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

Lassen County Behavioral Health provides ongoing engagement services to individuals enrolled in Full Service Partnership (FSP) Intensive Case Management (ICM) through a comprehensive, person centered approach. The County maintains low staff to client ratios, allowing teams to offer highly individualized care, frequent contact, and consistent engagement based on each participant's needs. Services are delivered through a multidisciplinary team model that includes clinicians, case managers, peer support specialists, and practitioners with lived experience. This structure ensures that care is coordinated, integrated, and culturally responsive. Ongoing communication and follow-up are core components of the program, with staff providing regular outreach and ensuring that each individual receives at least one service per week, as clinically indicated. To reduce barriers and enhance engagement, Lassen County offers services in flexible and accessible settings, including home, community, and field-based environments. This approach allows staff to meet participants where they are, both geographically and in their recovery journey.

LCBH provides ongoing engagement services through consistent, community-based outreach and coordination with local partners. Staff conduct monthly in-person outreach alongside community partners to maintain contact, monitor client needs, and reinforce treatment engagement. These joint visits allow us to build trust, address barriers in real time, and connect clients with essential supports such as housing, medical care, and other community resources. Given our rural geography, this collaborative, mobile approach is critical to ensuring continuous engagement and accessibility of services for individuals in FSP ICM.

- a. (Optional) 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

N/A

- 6. 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.)

LCBH will maintain compliance with required FSP levels of care by ensuring FSP ICM teams meet intensity standards, transitioning where required, and standing up new FSP ICM teams as needed based on service demand. Team structures, staffing, and service delivery will be monitored to meet BHSA requirements and support participant needs.

- 7. Please indicate whether the county FSP program will include any of the following optional and allowable services: N/A

- a. Primary substance use disorder (SUD) FSPs

Yes

- i. LCBH will coordinate with on-site SUD counselors and Managed Care Plan on providing FSP for primary SUD individuals.

- b. 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)

Yes

- i. Please describe the outreach activities the county will engage in to enroll individuals living with significant behavioral health needs into the county's FSP program

Lassen County enrolls individuals with significant behavioral health needs into its Full-Service Partnership (FSP) program through robust outreach efforts that extend well beyond traditional referral systems. These efforts include BHSA-funded community outreach and engagement events, partnerships with grassroots organizations. The county also develops a centralized Access Line and utilizes help from community members to connect with the appropriate level of care. In addition, FSP teams conduct face-to-face outreach in shelters, hospitals, jails, encampments, and other community settings, supported by peer specialists and case management staff. These multi-channel strategies

ensure that individuals with the greatest needs are identified, engaged, and successfully enrolled into comprehensive FSP services. By prioritizing culturally responsive and community-driven outreach, Lassen County works to reduce disparities and expand access for underserved populations. FSP staff further support the county's homeless services efforts by providing accessible resources and linkages to housing programs, basic needs support, Medi-Cal enrollment, the Behavioral Health Access Line, and direct connection to FSP services.

c. Other recovery-oriented services

No

8. 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"

N/A

9. 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:

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

In developing its FSP program, Lassen County Behavioral Health conducted a range of activities to address the unique needs of children and youth who are in, or at risk of entering, the juvenile justice system. The county reviewed juvenile justice data and annual planning documents, gathered input from the Juvenile Justice Coordinating Council, and engaged in focus groups, interviews, and surveys with youth, families, probation staff, schools, and community partners.

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

LCBH analyzed demographic and service data and consulted with local LGBTQ+ organizations and providers to ensure FSP services address unique needs and promote safe, affirming engagement.

c. In the child welfare system

LCBH reviewed child welfare data and collaborated with Social Services, foster care providers, and clinicians to design FSP services that support stability and meet the needs of system-involved youth.

10. 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:

a. Older adults

LCBH reviewed demographic and service data and engaged senior service providers and healthcare partners to inform FSP service design that addresses housing, behavioral health, and social support needs for older adults.

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

LCBH analyzed demographic and service data and consulted with local LGBTQ+ organizations and community providers to ensure FSP services are culturally responsive and accessible.

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

LCBH is involved in PATH Grant to provide pre-release services to incarcerated individuals and identify barriers to entering behavioral health care.

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](#).

1. Please describe the county behavioral health system's approach and timeline(s) to support and implement assertive field-based initiation for SUD treatment services program requirements by listing the existing and new programs (as applicable) that the county will leverage to support the assertive field-based SUD program requirements and provide the current funding source, BHSA service expansion, and the expected timeline for meeting programmatic requirements to expand existing programs and/or stand up new initiatives before July 1, 2029. Counties should include programs not funded directly or exclusively by BHSA dollars. Additional information regarding assertive field-based initiation for SUD treatment services can be found in the BHSA Policy Manual [Chapter 7, Section B.6](#).

Table 25. Existing Programs for Assertive Field-Based SUD Treatment Services

Requirement	Existing Program	Program Description	Current Funding Source	BHSA Changes to Existing Program(s) to Meet BHSA Requirements	Expected Timeline of Operation
Targeted Outreach	N/A	N/A	N/A	N/A	N/A
Mobile Field-Based Program(s)	N/A	N/A	N/A	N/A	2027
Open-Access Clinic(s)	N/A	N/A	N/A	N/A	N/A

Table 26. New Programs for Assertive Field-Based SUD Treatment Services

Requirement	New Program(s)	Program Description(s)	Planned Funding	Planned Operations	Expected Timeline of Implementation
Targeted Outreach	SUD Field Based Outreach	To assess the gap between the current community field-based outreach program and the new requirement of an Assertive Field Based SUD treatment program to meet estimated needs, the County will	BHSA, Drug Medi-Cal	TBD	7/1/2029

		implement a data-driven, equity-focused approach that integrates utilization and population level data. This assessment will estimate current system capacity, identify disparities in access and utilization, and inform strategic service planning for an Assertive Field based SUD program in Lassen County. Utilization data from existing monthly community outreach program will be used to establish a baseline of available resources, including the service locations by zip code, number and type of providers, services and resources, and total clients served. Analyses will examine client characteristics by race/ethnicity, gender, age, and geography, enabling the County to determine the frequency and need of an Assertive Field based Outreach model. The data will focus on incorporating the best practice approach of harm reduction, linking to primary care, post overdose follow up engagement services and access to peer support services.			
Mobile Field-Based Program(s)	Mobile SUD Services	To assess the gap between the current community field-based outreach program and the new requirement of a mobile field-based program to meet estimated needs, the County will implement a data-driven, equity-focused approach that integrates utilization and population level data. This assessment will	BHSA, Drug Medi-Cal	TBD	7/1/2029

		estimate current system capacity, identify disparities in access and utilization, and inform strategic service planning for mobile field-based program in Lassen County. Utilization data from existing monthly community outreach program will be used to establish a baseline of available resources, including the service locations by zip code, number and type of providers, services and resources, and total clients served. Analyses will examine client characteristics by race/ethnicity, gender, age, and geography, enabling the County to determine the frequency and need of a mobile field-based program.			
Open-Access Clinic(s)	Lassen County Open Access Clinic	To assess the gap between current Open Access clinics already established in partnering Counties and creating a new Open Access clinic in Lassen County to meet estimated needs, the County will implement a data-driven, equity-focused approach that integrates utilization and population level data. This assessment will estimate current system capacity, identify disparities in access and utilization, and inform strategic service planning for Open Access clinics in Lassen County. Utilization data from existing Counties will be used to establish a baseline of available resources, including the service locations by zip code, number and type of providers, services and	BHSA, Drug Medi-Cal	TBD	7/1/2029

		resources offered and total clients served. Analyses will examine client characteristics by race/ethnicity, gender, age, and geography, enabling the County to assess utilization patterns and capacity through a health equity lens across the system of care.			
--	--	---	--	--	--

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.]

1. 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

To assess the gap between current county medication-assisted treatment (MAT) resources and the resources required to meet estimated needs, the County will implement a data-driven, equity-focused approach that integrates utilization and population level data. This assessment will estimate current system capacity, identify disparities in access and utilization, and inform strategic service planning to meet the needs of the community for MAT.

Utilization data from existing MAT providers (Currently one in Lassen County-Lassen Indian Health) will be used to establish a baseline of available resources, including the service locations by zip code, number and type of providers, medications offered (e.g., methadone, buprenorphine, naltrexone), and total clients served. Analyses will examine client characteristics by race/ethnicity, gender, age, and geography, enabling the County to assess utilization patterns and capacity through a health equity lens across the system of care.

Data will help estimate the underlying need for MAT services using both quantitative and qualitative measures. Quantitative measures will include data on individuals who visited an emergency department or were hospitalized for opioid use disorder (OUD) or opioid overdose in the past year, stratified by zip code, and limited to Medi-Cal eligible individuals to highlight our service population.

Qualitative input gathered from community engagement sessions will be incorporated to capture resident and stakeholder perspectives on MAT resource gaps and barriers to care. Through a comprehensive review of data and community feedback, the County will compare existing MAT resources with estimated need to identify areas where capacity can be expanded, access barriers can be improved, and investments are most needed to ensure equitable access to MAT resources across Lassen County.

2. Select the following practices the county will implement to ensure same day access to MAT
 - a. Contract directly with MAT providers in the county
 - b. Enter into referral agreements with other MAT providers including providers whose services are covered by Medi-Cal MCPs and/or Fee-For-Service (FFS) Medi-Cal
 - c. Leverage telehealth model(s)

3. What forms of MAT will the county provide utilizing the strategies selected above?
 - a. Buprenorphine
 - b. Naltrexone
 - c. Other
 - i. Please specify other forms of MAT
Suboxone

Housing Interventions

Planning

For related policy information, refer to [7.C.3 Program priorities](#) and [7.C.4 Eligible and priority populations](#).

System Gaps

1. 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

- a. Supportive housing
Large Gap
- b. Apartments, including master-lease apartments
Large Gap
- c. Single and multi-family homes
Large Gap
- d. Housing in mobile home communities
Medium Gap
- e. (Permanent) Single room occupancy units
Large Gap
- f. (Interim) Single room occupancy units
Medium Gap
- g. Accessory dwelling units, including junior accessory dwelling units
Large Gap
- h. (Permanent) Tiny homes
Large Gap
- i. Shared housing
Large Gap
- j. (Permanent) Recovery/sober living housing, including recovery-oriented housing
Large Gap
- k. (Interim) Recovery/sober living housing, including recovery-oriented housing
Medium Gap
- l. Assisted living facilities (adult residential facilities, residential facilities for the elderly, and licensed board and care)
Large Gap
- m. License-exempt room and board
Large Gap
- n. Hotel and Motel stays
Medium Gap
- o. Non-congregate interim housing models
Large Gap
- p. Congregate settings that have only a small number of individuals per room and sufficient common space (does not include behavioral health residential treatment settings)
Large Gap
- q. Recuperative Care
Large Gap

- r. Short-Term Post-Hospitalization housing
Large Gap
 - s. (Interim) Tiny homes, emergency sleeping cabins, emergency stabilization units
Large Gap
 - t. Peer Respite
Large Gap
 - u. Permanent rental subsidies
Medium Gap
 - v. Housing supportive services
Large Gap
2. 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](#)?

Lassen County Behavioral Health will continue to leverage existing non-BHSA resources and interdepartmental partnerships to expand housing access for BHSA-eligible individuals. This includes ongoing collaboration with the Lassen County Community Social Services through programs already underway, such as the Behavioral Health Bridge Housing (BHBH) Program and the Local Incentive for Medical Respite (LICN) grant, which support interim housing and medical respite options for individuals experiencing homelessness with complex behavioral health and medical needs. The County also coordinates with the local Continuum of Care and Housing Authority to utilize available rental assistance and voucher programs when feasible and available.

At the state and federal level, the County will continue to align behavioral health services with Medi-Cal and CalAIM initiatives, including Enhanced Care Management and applicable Community Supports, as well as HUD-funded homelessness programs. The County will also pursue data-sharing and referral coordination across Behavioral Health, Housing, Social Services, and partner agencies to improve identification, prioritization, and linkage to housing resources. Given the County's rural context and limited housing inventory, these efforts are focused on maximizing existing programs and partnerships while assessing opportunities to incrementally expand access over time.

3. 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?

BHSA Housing Interventions will be used to complement and strengthen existing housing and homelessness efforts in Lassen County by aligning behavioral health services with housing resources already underway, including the Behavioral Health

Bridge Housing (BHBH) Program and the Local Incentive for Medical Respite (LICN) grant. BHSA-funded interventions will support service coordination, housing navigation, and stabilization activities that help individuals move through the housing continuum—from interim and recuperative settings to more stable housing options—while addressing behavioral health needs that may otherwise create barriers to placement or retention. The housing department also utilizes Peers Support. BHSA Housing Interventions will also intersect with Medi-Cal and CalAIM initiatives, including Enhanced Care Management and applicable Community Supports, to promote continuity of care and reduce duplication across systems. Through coordination and data-sharing among Behavioral Health, Housing, Social Services, and partner agencies, the County will prioritize BHSA-eligible individuals with the highest needs and leverage existing non-BHSA resources to maximize impact. In a rural context with limited housing inventory, BHSA interventions will be strategically applied to fill service gaps, enhance linkage and engagement, and strengthen the overall continuum of housing supports rather than operate as standalone housing programs.

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

Lassen County Behavioral Health’s overall strategy to promote permanent housing placement and retention for individuals receiving BHSA Housing Interventions focuses on community education and reducing permanent housing stigma within the County. Also, focuses on integrating behavioral health services with housing navigation, care coordination, and stabilization supports to reduce barriers to placement and support housing sustainability. BHSA Housing Interventions will complement existing interim housing resources, including Behavioral Health Bridge Housing and medical respite, by supporting transitions into permanent housing when available and addressing behavioral health needs that impact housing stability. The County will align these efforts with Medi-Cal and CalAIM services, including Enhanced Care Management and applicable Community Supports, to promote continuity of care, strengthen engagement, and support long-term housing retention within the County’s limited housing inventory.

5. 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)?

The county behavioral health system engages in several activities to connect BHSA-eligible individuals to permanent supportive housing (PSH) and support their housing stability. These activities include:

- Participation in regional housing efforts: The county is a member of the Lassen County Advisory Board to the NorCal Continuum of Care, collaborating with regional partners to identify housing opportunities and coordinate services for individuals experiencing homelessness or housing instability.
- Outreach and engagement: Behavioral health staff conduct outreach to individuals in need, helping them navigate available resources and connect to housing programs.
- Supportive services: The county provides a range of supportive services to assist individuals in PSH or other permanent housing, including mental health counseling, substance use treatment, and case management.
- Housing referrals: Staff refer clients to existing housing programs and services, helping them access rental assistance, supportive housing projects, or other permanent housing options.
- Funding and resource support: While the county does not directly provide rental subsidies, operating subsidies, or capital development funding for PSH projects, it supports these efforts indirectly through partnerships, referrals, and coordination with regional and local housing programs. This approach ensures that BHSA-eligible individuals have access to both housing opportunities and the supportive services needed to maintain long-term housing stability.

6. 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

Lassen County Behavioral Health will ensure that all Housing Interventions settings provide access to clinical and supportive behavioral health care through coordinated service delivery and established referral pathways rather than reliance on on-site service models. BHSA-eligible individuals placed in housing settings will be connected to appropriate behavioral health services, including outpatient treatment, care coordination, and crisis response, based on individual need. Housing providers and partner agencies will have clear points of contact within Behavioral Health to facilitate referrals, information sharing, and timely access to services. Supportive housing services, including housing navigation, tenancy support, and stabilization services, will be integrated with clinical care through coordination with Medi-Cal and CalAIM services, including Enhanced Care Management and applicable Community Supports. Through ongoing collaboration among Behavioral Health, Housing, Social Services, and community partners, the County will monitor service access, address barriers as they arise, and ensure continuity of care across housing settings within the County's rural service delivery environment. BH and Housing are currently working to pursue the contract with Partnership regarding the Transitional Rent.

Eligible Populations

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

Lassen County Behavioral Health will identify and screen all clients for housing needs upon registration and continue to monitor clients housing needs based on continuous tracking in the electronic health record system, outcome measures (LOCUS and DLA-20) and clients self-report. LCBH will also refer clients to Coordinated Entry system to determine the most appropriate housing program.

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

Yes

3. 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:

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

Lassen County Behavioral Health and other community partners (Child and Family Services, Juvenile probation, Public Health, Office of Education, etc.) participate in monthly Service Allocation Teams (SAT) to discuss at risk youth and their family regarding housing needs and concerns. Also, behavioral health staff also participate in Wraparound services which also identifies possible housing needs or concerns. Lassen County Behavioral Health reviews local data and client-data on youth involved or at risk of involvement in the juvenile justice system. The County considered these data alongside housing instability indicators, behavioral health needs, and evidence-based practices to inform Housing Interventions services. Stakeholder engagement includes consultations with probation officers, juvenile case managers, and providers serving system-involved youth to identify barriers to housing access and supports necessary for stable placements.

- b. Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)

The County reviewed demographic and service data, including EHR documentation and community assessments, to understand the unique housing and behavioral health needs of LGBTQ+ youth and young adults. Stakeholder engagement includes collaboration with local advocacy groups, community-based providers, and school-based support programs to identify culturally responsive strategies and supports that promote safe, affirming, and stable housing options within Housing Interventions services.

- c. In the child welfare system

Lassen County Behavioral Health and other community partners (Child and Family Services, Juvenile probation, Public Health, Office of Education, etc.) participate in monthly Service Allocation Teams (SAT) to discuss at risk youth and their family regarding housing needs and concerns. Also, behavioral health staff also participate in Wraparound services which also identifies possible housing needs or concerns. Behavioral Health works to engage with the Child and Family Services, foster care programs, and case management teams to review data on children and youth involved in or transitioning out of the child

welfare system. Input from social workers, foster care providers, and behavioral health clinicians inform the development of Housing Interventions services to address housing instability, behavioral health needs, and supportive services that facilitate successful placement and retention in stable housing.

4. 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:
 - a. Older adults

Lassen County Behavioral Health and other community partners (Adult Protection Services, Probation, Jail/incarceration, Public Health, Medical Centers, etc.) participate in monthly Adult System of Care (ASOC) meetings to discuss older adults regarding housing needs and concerns. Also, behavioral health staff participate monthly in Elder Multidisciplinary Teams through Lassen Family Services (LFS) which also identifies possible housing needs or concerns. Lassen County Behavioral Health reviewed local demographic data, housing needs assessments, and behavioral health service utilization patterns to identify the unique needs of older adults experiencing or at risk of homelessness. The County engages stakeholders including Adult Services, local senior centers, housing providers, and healthcare partners to inform Housing Interventions strategies that support aging in place, access to appropriate behavioral health services, and stable housing placements for older adults.
 - b. In, or are at risk of being in, the justice system

Lassen County Behavioral Health and other community partners (Adult Protection Services, Probation, Jail/incarceration, Public Health, Medical Centers, etc.) participate in monthly Adult System of Care (ASOC) meetings to discuss older adults regarding housing needs and concerns. Also, behavioral health staff participate in Cal-Aim 90-day prelease of anyone coming out of the jail regarding any possible housing needs or concerns prior to release from jail. The County collaborates with Probation, local law enforcement, the County Court, and community-based reentry providers to review data on justice-involved and at-risk adults, including prior housing instability and behavioral health needs. Stakeholder input informs Housing Interventions development to address barriers to housing access, connect individuals to supportive services, and facilitate stable housing placements as part of successful reintegration into the community.
 - c. In underserved communities

Lassen County Behavioral Health has identified communities as underserved and underserved (Bieber, Westwood, Herlong/Doyle/Ravendale/Termo). Currently working with local community partners to create a mobile van to reach out to the underserved communities regarding housing needs. Behavioral Health reviewed local demographic, social determinant, and service utilization data to identify underserved communities experiencing housing instability and behavioral health needs. Engagement with community-based organizations, culturally specific service providers, and public health partners inform strategies to ensure Housing Interventions services are equitable, accessible, and culturally responsive, including consideration of language, transportation, and other barriers that may affect housing access and retention.

Local Housing System Engagement

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

Lassen County Behavioral Health is currently a voting member with the Housing Advisory Board which is part of the CoC system. The CoC consists of 7 other Counties and uses the HMIS system for referrals. Lassen County Behavioral Health will coordinate with the Continuum of Care (CoC) by collaborating closely with the Housing Department and other CoC partners to ensure timely identification and referral of BHSA-eligible individuals. Referrals for Housing Interventions services will be received through the Housing Department (or identified internally and coordinated with Housing) as well as through Lassen Links, the County's coordinated entry system, allowing for streamlined access to housing supports and behavioral health services. Behavioral Health staff will work with partner agencies to assess eligibility, prioritize individuals with the highest needs, and facilitate linkage to appropriate Housing Interventions resources while maintaining ongoing communication across systems.

2. 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

- a. Local CoC

Lassen County Behavioral Health collaborates with the local Continuum of Care (CoC) by participating in planning meetings, sharing data on behavioral health service needs, and coordinating referrals for Housing Interventions. The County works with CoC partners to identify housing opportunities, align interventions with CoC priorities, and ensure BHSA-eligible individuals are connected to available housing resources, including interim and permanent supportive housing options. Nor COC (7 Counties). Formal voting member of the housing Advisory Board.

- b. Public Housing Agency

The Public Housing Authority for Lassen County is located and operated out of Plumas County. At this time the Public Housing Agency is currently not available (the Public Housing list is closed with no timeline of when it will open again). When the Public Housing Agency opens again, Behavioral Health will coordinate referrals for rental assistance and housing placement for BHSA-eligible individuals. The County leverages Housing Authority programs, including Housing Choice Vouchers and any applicable waitlist prioritization processes, to support placement into stable housing and integrates behavioral health services to promote retention and tenancy stability.

c. MCPs

Lassen County Behavioral Health is currently working on a MOU with Partnership managed Care and Lassen County Housing and Grants Department regarding Transitional Rent. The County will collaborate with Medi-Cal MCP (Partnership) to identify individuals eligible for housing interventions, share relevant behavioral health information, coordinate care and transition to appropriate level-of-care. This partnership supports linkage to housing resources, integration of clinical services, and alignment with MCP care management initiatives to ensure that behavioral health needs are addressed alongside housing stability.

d. ECM and Community Supports Providers

LCBH coordinates with Medi-Cal Managed Care Plan, Partnership HealthPlan, in the implementation of Enhanced Care Management (ECM) while continuing to provide targeted case management for BHSA-eligible individuals. Case managers work directly with Community Supports providers to connect individuals to housing-related Supports, including Housing Transition and Navigation Services, Energy and rental assistance, Housing Tenancy and Sustaining Services, and Recuperative Care when applicable.

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

In addition to formal partnerships with the CoC, PHAs, and Medi-Cal/ECM providers, the county behavioral health system collaborates with other housing-related programs and providers. Staff refer clients to CalWORKS/TANF programs, such as the Housing Support Program (HSP) through Lassen Works and the Bringing Family Housing (BFH) program through Lassen County Housing and Grants.

3. 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?

Lassen County does not have Homekey+ program, but LCBH will work with Lassen County Housing and Grants on Homekey supportive housing. Currently 15 units are being developed in the community (10 units for 18-24 years old) for individuals experiencing homelessness. LCBH will coordinate with the Housing and Grants Department, Continuum of Care partners, and Homekey supportive housing sites to facilitate referrals of BHSA-eligible individuals and align behavioral health services with housing placements.

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

No

BHSA Housing Interventions Implementation

[Context text: 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](#))

[Context text: 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)]

1. Is the county providing this intervention?
Yes
2. Is the county providing this intervention to chronically homeless individuals?
Yes
3. How many individuals does the county behavioral health system expect to serve with rental subsidies under BHSA Housing Interventions on an annual basis? 30
 - a. How many of these individuals will receive rental subsidies for permanent housing on an annual basis? 0
 - b. How many of these individuals will receive rental subsidies for interim housing on an annual basis? 30
4. 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?
Based on BHSA allocation and total number of SMI clients. Currently use Fair Market Rent Estimate on how much you will pay on rental subsidies.
5. 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: 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

6. Will this Housing Intervention accommodate family housing?

Yes

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

If housing instability is identified for a BH client, that client will be referred to Housing and worked one-on-one with the Housing department and an assigned Case Manager to navigate the process of applying for and receiving rental assistance.

8. 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?

a. Project-based

b. Tenant-based

9. 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

LCBH will collaborate with Lassen County Housing and Grants, the Continuum of Care, City of Susanville, county departments, community-based organizations, landlords, and other local partners to identify and maintain a diverse portfolio of housing opportunities for BHSA-eligible individuals. Coordination efforts will include regular partner meetings to review housing availability, barriers to access, and resource needs, while supporting a range of housing options including scattered-site units, transitional housing, permanent supportive housing, project-based housing, and master leasing/Flex Pool strategies when available and appropriate. LCBH and partner agencies will also coordinate housing navigation, referrals, and supportive services to improve housing access and stability for individuals with behavioral health needs.

10. Total number of units funded with BHSA Housing Interventions per year
30

Operating Subsidies ([Chapter 7, Section C.9.2](#))

1. Is the county providing this intervention?
Yes
2. Is the county providing this intervention to chronically homeless individuals?
Yes
3. Anticipated number of individuals served per year
30

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

LCBH will use BHSA Housing Interventions funding to support operating subsidies for housing units serving individuals with behavioral health needs, including chronically homeless individuals. Funding may be used for housing operation and management costs such as property administration, maintenance, utilities, insurance, security, and other expenses necessary to maintain safe, stable, and supportive housing environments. Operating subsidies will support housing stability and ongoing access to housing resources for eligible individuals and families.

5. For which setting types will the county provide operating subsidies?
Time Limited Interim Settings: Hotel and motel stays
Time Limited Interim Settings: Non-congregate interim housing models
6. Will this be a scattered site initiative?
Yes

7. Will this Housing Intervention accommodate family housing?

Yes

8. Total number of units funded with BHSA Housing Interventions per year

30

9. [Optional question] 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

N/A

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

1. Is the county providing this intervention?
Yes
2. Is the county providing this intervention to chronically homeless individuals?
Yes
3. Anticipated number of individuals served per year
30
4. Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
LCBH will develop an MOU with Lassen County Housing and Grants to implement landlord outreach and mitigation activities that support housing access and stability for BHSA-eligible individuals. BHSA Housing Interventions funding will be used for landlord engagement, risk mitigation funds, housing-related supports, and coordination efforts to encourage landlord participation and reduce barriers to securing and maintaining housing for individuals with behavioral health needs.
5. Total number of units funded with BHSA Housing Interventions per year
30
6. [Optional question] Please provide additional details to explain if the county is providing landlord outreach and mitigation funds with BHSA Housing Interventions that are not tied to a specific number of units
N/A

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

1. Is the county providing this intervention?
Yes
2. Is the county providing this intervention to chronically homeless individuals?
Yes
3. Anticipated number of individuals served per year
30
4. Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
LCBH will develop an MOU with Lassen County Housing and Grants to support increased training needs for existing and newly hired staff related to the implementation of evidence-based practices, integrated care approaches, documentation and reporting requirements, cultural responsiveness, and other BHSA-related program changes.

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)].

1. Is the county providing this intervention?

Yes

2. Is the county providing this intervention to chronically homeless individuals?

Yes

3. Anticipated number of individuals served per year

30

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

LCBH provides Housing Transition Navigation and Tenancy Sustaining Services to BHSA-eligible individuals, including chronically homeless participants, through coordination with case managers. BHSA funding supports staff time for care coordination, outreach, and connection to behavioral health, housing, and supportive services to promote stable placement and tenancy retention.

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

1. Is the county providing this intervention?
Yes
2. Is the county providing this intervention to chronically homeless individuals?
Yes
3. Anticipated number of individuals served per year
2000
4. Please provide a brief description of the intervention, including specific uses of BHSa Housing Interventions funding

LCBH conducts outreach in partnership with the Housing and Grants Department to connect BHSa-eligible individuals, including chronically homeless participants, to housing supports. Outreach activities include engagement in underserved areas, shelters, community events, fairs, school board meetings, and targeted radio and newspaper advertising. BHSa funding supports staff time, coordination, and materials needed to implement these outreach and engagement efforts. Also, engagement of individuals at Peer Run Drop-In-Center (Judy's House).

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

1. 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
 - a. Please explain why the county is not providing this intervention
Currently expanding BHBH program.

Other Housing Interventions (Optional)

1. If the county is providing another type of Housing Interventions not listed above, please describe the intervention
N/A
 - a. Is the county providing this intervention to chronically homeless individuals?
N/A
 - b. Anticipated number of individuals served per year
N/A

Continuation of Existing Housing Programs

1. 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)

LCBH will use BHSA Housing Interventions funding to continue existing programs, including BHBH Bridge Housing and LICN medical respite, and to support development of a transitional housing facility for transitional age youth, youth aged out of foster care, and other transitional housing for homeless individuals with SMHS. Funding will support service coordination, case management, and connection to behavioral health and supportive services for individuals placed in these programs.

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](#)

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

Transitional Rent

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

Housing Transition Navigation Services

Undecided

Housing Deposits

Undecided

Housing Tenancy and Sustaining Services

Undecided

Short-Term Post-Hospitalization Housing

Undecided

Recuperative Care

Undecided

Day Habilitation

Undecided

Transitional Rent

Yes

- i. When does the county behavioral health system plan to become an MCP-contracted provider?

7/1/2026

3. 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)?

LCBH will work with Lassen County Housing and Grants and MCP (Partnership) on identifying Medi-Cal members for the most appropriate programs including transitional rent. LCBH identifies Medi-Cal members eligible for housing-related Community Supports through EHR data, living arrangement documentation, and referrals from BH programs, hospitals, shelters, and community partners. Eligibility is confirmed through coordination with the MCP, and LCBH case managers facilitate referrals to Transitional Rent and other housing-related Community Supports while monitoring

service engagement and needs.

4. 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

LCBH maintains ongoing coordination with MCPs by sharing the Housing Interventions provider network through regular communication, referral protocols, and care coordination meetings. Case managers and program staff ensure MCPs are aware of available housing resources and supports, and updates to the provider network are shared promptly to facilitate timely referrals for BHSA-eligible individuals.

5. 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)?

Yes

- a. Please describe the county behavioral health system's coordination efforts to align network development

LCBH tracks which contracted housing providers are also part of MCP housing-related Community Supports networks. Coordination includes regular communication with MCPs, updating referral lists, and aligning case management efforts to ensure BHSA-eligible individuals are connected to the most appropriate and available housing supports.

6. 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?

LCBH monitors MCP housing service use through case managers and EHR data to identify when members are nearing service limits. Case managers coordinate with MCPs, Housing Department, and community partners to connect individuals to alternative BHSA-funded housing supports, community resources, or other available programs to minimize gaps in service and maintain housing stability.

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](#).

1. 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

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

No

3. 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.

1. Does the county’s plan include the development of innovative programs or pilots?

No

Workforce Strategy

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:

1. [Maintains and monitors](#) a network of providers that is sufficient to provide adequate access to services and supports for individuals with behavioral health needs; and
2. Meets [federal and state standards](#) for timely access to care and services, considering the urgency of the need for services.
3. 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.

a. 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

b. 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

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

36%

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

BH-SUD Org Chart 2026.xlsx

3. For county behavioral health (including county-operated providers), please select the [five positions](#) with the greatest vacancy rates [multi-select dropdown]

- a. Licensed Clinical Social Worker
- b. Licensed Marriage and Family Therapist
- c. Licensed Professional Clinical Counselor
- d. Substance Use Disorder Counselor
- e. Other qualified provider

4. Please describe any other key workforce gaps in the county

Lassen County is unable to find full-time in-person therapists and prescribers and has to rely on contracts and telehealth. LCBH also has a Fiscal officer position that has remained vacant since 2024 and has not received any qualified applicants - 1 clinical supervisor position has been unable to be filled, compliance officer, SUD Counselor – all of which the BHP has made great strides to outreach and post jobs for but have received no qualified interest. As a small county, many clinicians see greater opportunity in larger counties unless already living and established in Lassen.

5. 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)?

The BHP expects difficulty in staffing over the next 3 fiscal years. Continuing with its difficulty in filling already vacant positions, the BHP foresees this problem to extend into the future. Lassen County as a whole is still seeing expected population decline and less qualified providers seeking residency. As requirements increase, the BHP foresees greater rates of staff burnout, retirements, and increased amount of expensive contracted providers in order to meet the needs in the face of resource drain over the next 3 years.

As new BHT, BH-CONNECT, and BHSA requirements are implemented, the BHP will implement increased trainings for current employees and new hires on EBPs, evolving documentation requirements, and new intervention and programs.

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.

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

No

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

No

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

No

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

No

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

No

6. 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

N/A

Budget And Prudent Reserve

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

[logic: download budget template button]

1. Please upload the completed [budget](#) template
2. 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 [helper text: if not applicable, enter N/A]
 - a. Behavioral Health Services and Supports (BHSS) N/A
 - b. Full Service Partnership (FSP) N/A
 - c. Housing Interventions N/A
3. [Enter date of last prudent reserve assessment](#) [3/3/2026]
4. 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 [helper text: if not applicable, enter N/A]
 - a. BHSS N/A
 - b. FSP N/A
 - c. Housing Interventions N/A

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	☒	\$ 40,000.00	\$ 41,600.00	\$ 43,264.00	\$ 10,000.00	\$ 10,400.00	\$ 10,816.00	1000	40
Early Intervention Services	☒	\$ 40,000.00	\$ 41,600.00	\$ 43,264.00	\$ 10,000.00	\$ 10,400.00	\$ 10,816.00	1000	40
Outpatient Services	☒	\$ 871,250.00	\$ 906,100.00	\$ 942,344.00	\$ 88,751.00	\$ 92,301.04	\$ 95,993.08	174	9
Intensive Outpatient Services	☒	\$ 25,000.00	\$ 26,000.00	\$ 27,040.00	\$ 5,000.00	\$ 5,200.00	\$ 5,408.00	5	1
Crisis and Field-Based Services	☒	\$ 50,000.00	\$ 52,000.00	\$ 54,080.00	\$ 10,000.00	\$ 10,400.00	\$ 10,816.00	10	2
Residential Treatment Services	☒	\$ 100,000.00	\$ 104,000.00	\$ 108,160.00	\$ 10,000.00	\$ 10,400.00	\$ 10,816.00	20	2
Inpatient Services	☒	\$ 30,000.00	\$ 31,200.00	\$ 32,448.00	\$ -	\$ -	\$ -	1	0
Mental Health (MH) Services									
Primary Prevention Services	☒	\$ 150,000.00	\$ 156,000.00	\$ 162,240.00	\$ 50,000.00	\$ 52,000.00	\$ 54,080.00	1000	40
Early Intervention Services	☒	\$ 150,000.00	\$ 156,000.00	\$ 162,240.00	\$ 50,000.00	\$ 52,000.00	\$ 54,080.00	1000	40
Outpatient and Intensive Outpatient Services	☒	\$ 3,050,000.00	\$ 3,172,000.00	\$ 3,298,880.00	\$ 1,150,000.00	\$ 1,196,000.00	\$ 1,243,840.00	620	260
Crisis Services	☒	\$ 400,000.00	\$ 416,000.00	\$ 432,640.00	\$ 300,000.00	\$ 312,000.00	\$ 324,480.00	135	58
Residential Treatment Services	☒	\$ 200,000.00	\$ 208,000.00	\$ 216,320.00	\$ 100,000.00	\$ 104,000.00	\$ 108,160.00	9	2
Hospital and Acute Services	☒	\$ 300,000.00	\$ 312,000.00	\$ 324,480.00	\$ 200,000.00	\$ 208,000.00	\$ 216,320.00	23	9
Subacute and Long-Term Care Services	☒	\$ 300,000.00	\$ 312,000.00	\$ 324,480.00	\$ 100,000.00	\$ 104,000.00	\$ 108,160.00	11	2
Housing Services (MH + SUD)									
Housing Services	☒	\$ 340,000.00	\$ 353,600.00	\$ 367,200.00	\$ 145,000.00	\$ 150,800.00	\$ 156,600.00	20	5
Total Projected Expenditures and Individuals Served									
Total Projected Expenditures and Individuals Served (auto-populated)		\$ 6,046,250.00	\$ 6,288,100.00	\$ 6,539,080.00	\$ 2,228,751.00	\$ 2,317,901.04	\$ 2,410,385.08	5028	510

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	\$ -	\$ -	\$ -
Workforce Investment Activities	\$ -	\$ -	\$ -
Quality & Accountability, Data Analytics, and Plan Management & Administrative Activities (including indirect administrative activities)	\$ 552,000.00	\$ 574,080.00	\$ 597,043.20
Other County Behavioral Health Agency Services/Activities (e.g., Public Guardian, CARE Act, LPS Conservatorships, DSH for Housing, Court Diversion Programs)	\$ 591,000.00	\$ 614,640.00	\$ 639,225.60
Total Projected Expenditures			
Total Projected Expenditures (auto-populated)	\$ 1,143,000.00	\$ 1,188,720.00	\$ 1,236,268.80

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	\$ 3,200,000.00	\$ 3,328,000.00	\$ 3,460,344.00
1991 Realignment (Bronzan-McCorquodale Act)	\$ 1,829,792.00	\$ 1,902,983.68	\$ 1,979,103.03
2011 Realignment (Public Safety Realignment)	\$ 1,227,270.00	\$ 1,276,360.80	\$ 1,327,415.23
State General Fund	\$ 281,477.00	\$ 292,736.08	\$ 304,445.52
FFP (SMHS, DMC/DMC-ODS, NSMHS)	\$ 2,611,250.00	\$ 2,715,700.00	\$ 2,824,328.00
Projects for Assistance in Transition from Homelessness (PATH)	\$ -	\$ -	\$ -
Community Mental Health Block Grant (MHBG)	\$ 148,622.00	\$ 154,566.88	\$ 160,749.56
Substance Use Block Grant (SUBG)	\$ 119,590.00	\$ 124,373.60	\$ 129,348.54
Commercial Insurance	\$ -	\$ -	\$ -
County General Fund	\$ -	\$ -	\$ -
Opioid Settlement Funds	\$ -	\$ -	\$ -
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)	\$ -	\$ -	\$ -
Other county mental health or SUD funding	\$ -	\$ -	\$ -
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)	\$ 9,418,001.00	\$ 9,794,721.04	\$ 10,185,733.88
Total Projected Expenditure Variance	\$ -	\$ -	\$ -
Auto-validation: Table 1: Behavioral Health Care Continuum Projected Expenditures	\$ 8,275,001.00	\$ 8,606,001.04	\$ 8,949,465.08
Auto-validation: Table 2: Other County Expenditures	\$ 1,143,000.00	\$ 1,188,720.00	\$ 1,236,268.80

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)	\$ 960,000.00	\$ 1,120,000.00	\$ 1,120,000.00	\$ 3,200,000.00
Year Two Component Allocation (dollars)	\$ 998,400.00	\$ 1,164,800.00	\$ 1,164,800.00	\$ 3,328,000.00
Year Three Component Allocation (dollars)	\$ 1,038,336.00	\$ 1,211,392.00	\$ 1,211,392.00	\$ 3,461,120.00
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)	30%	35%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	\$ 960,000.00	\$ 1,120,000.00	\$ 1,120,000.00	\$ 3,200,000.00
Unspent Mental Health Services Act (MHSA) to BHSA	\$ 2,092,967.52	\$ 2,092,967.52	\$ 2,093,689.48	\$ 6,279,624.51
Excess Prudent Reserve (PR) to BHSA	\$ (69,199.07)	\$ (69,199.07)	\$ (69,199.07)	\$ (207,597.22)
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)	30%	35%	35%	100%

Projected Component Allocation (Based on Adjusted Allocation Percentages)	\$	998,400.00	\$	1,164,800.00	\$	1,164,800.00	\$	3,328,000.00
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)	30%		35%		35%		100%	
Projected Component Allocation (Based on Adjusted Allocation Percentages)	\$	1,038,336.00	\$	1,211,392.00	\$	1,211,392.00	\$	3,461,120.00
Funding Transfer Request Allocations								
Behavioral Health Services Fund (BHSP) 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%	\$	960,000.00					
Percentage Reduced	0%	\$	-					
Percentage Added	0%	\$	-					
New Housing Interventions Base Percentage (auto-populated)	30%	\$	960,000.00					
Transferred To/From	Full Service Partnership Percentage (Year One)		Full Service Partnership Funds (Year One)					
Base Percentage and Funding	35%	\$	1,120,000.00					
Percentage Reduced	0%	\$	-					
Percentage Added	0%	\$	-					
New FSP Base Percentage (auto-populated)	35%	\$	1,120,000.00					
Transferred To/From	Behavioral Health Services and Support Percentage (Year One)		Behavioral Health Services and Support Funding (Year One)					
Base Percentage and Funding	35%	\$	1,120,000.00					
Percentage Reduced	0%	\$	-					
Percentage Added	0%	\$	-					
New BHSS Base Percentage (auto-populated)	35%	\$	1,120,000.00					
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)	30%		35%		35%		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)	30%		35%		35%		Row Equals 100%	
Behavioral Health Services Fund (BHSP) 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%	\$	998,400.00					
Percentage Reduced	0%	\$	-					
Percentage Added	0%	\$	-					
New Housing Interventions Base Percentage (auto-populated)	30%	\$	998,400.00					

Transferred To/From	Full Service Partnership Percentage (Year Two)	Full Service Partnership Funds (Year Two)		
Base Percentage and Funding	35%	\$ 1,164,800.00		
Percentage Reduced	0%	\$ -		
Percentage Added	0%	\$ -		
New FSP Base Percentage (auto-populated)	35%	\$ 1,164,800.00		
Transferred To/From	Behavioral Health Services and Support Percentage (Year Two)	Behavioral Health Services and Support Funding (Year Two)		
Base Percentage and Funding	35%	\$ 1,164,800.00		
Percentage Reduced	0%	\$ -		
Percentage Added	0%	\$ -		
New BHSS Base Percentage (auto-populated)	35%	\$ 1,164,800.00		
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)	30%	35%	35%	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)	30%	35%	35%	Row Equals 100%
Behavioral Health Services Fund (BHSP) 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%	\$ 1,038,336.00		
Percentage Reduced	0%	\$ -		
Percentage Added	0%	\$ -		
New Housing Interventions Base Percentage (auto- populated)	30%	\$ 1,038,336.00		
Transferred To/From	Full Service Partnership Percentage (Year Three)	Full Service Partnership Funds (Year Three)		
Base Percentage and Funding	35%	\$ 1,211,392.00		
Percentage Reduced	0%	\$ -		
Percentage Added	0%	\$ -		
New FSP Base Percentage (auto-populated)	35%	\$ 1,211,392.00		
Transferred To/From	Behavioral Health Services and Support Percentage (Year Three)	Behavioral Health Services and Support Funding (Year Three)		
Base Percentage and Funding	35%	\$ 1,211,392.00		
Percentage Reduced	0%	\$ -		
Percentage Added	0%	\$ -		
New BHSS Base Percentage (auto-populated)	35%	\$ 1,211,392.00		
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)	30%	35%	35%	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)	30%	35%	35%	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	\$ 3,336,506.73	\$ 1,112,168.91	\$ 1,112,168.91	\$ 1,112,168.91
PEI	\$ 2,391,353.53	\$ 797,117.84	\$ 797,117.84	\$ 797,117.84
Encumbered INN	\$ 551,042.29	\$ 183,680.76	\$ 183,680.76	\$ 183,680.76
Unencumbered INN	\$ -	\$ -	\$ -	\$ -
WET	\$ 705.01			\$ 705.01
CFTN	\$ 16.95			\$ 16.95
Total (auto-populated)	\$ 6,279,624.51	\$ 2,092,967.52	\$ 2,092,967.52	\$ 2,093,689.48
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	\$ 614,780.00			
Local Prudent Reserve Maximum (2)	\$ 822,377.22			
Excess Prudent Reserve Funding that must be transferred	\$ (207,597.22)			
Housing Intervention (3)	\$ (69,199.07)			
FSP	\$ (69,199.07)			
BHSS (4)	\$ (69,199.07)			
Total Transferred Excess Prudent Reserve (auto-populated)	\$ (207,597.22)			
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)	\$ 960,000.00	\$ 998,400.00	\$ 1,038,336.00
Transfers into Housing Intervention component from Local Prudent Reserve	\$ 69,199.07	\$ 71,967.04	\$ 74,845.72
Total Estimated Housing Intervention Funding Allocated (MHSA - Unspent Carryover Funds)	\$ 2,092,967.52	\$ 2,176,686.22	\$ 2,263,753.67
Total Estimated Housing Intervention Funding (BHSA + MHSA Funds)	\$ 3,122,166.00	\$ 3,247,053.00	\$ 3,376,935.00

Housing Interventions Category

Type of Service	Projected Expenditures - Unspent MHSA and BHSFunding Only (Year One)	Projected Expenditures - Unspent MHSA and BHSFunding Only (Year Two)	Projected Expenditures - Unspent MHSA and BHSFunding 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	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Bundled Rental and Operating Subsidies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
% 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	\$ 124,685.11	\$ 129,672.51	\$ 134,859.41	\$ -	\$ -	\$ -
Operating Subsidies	\$ 124,685.11	\$ 129,672.51	\$ 134,859.41	\$ -	\$ -	\$ -
Bundled Rental and Operating Subsidies	\$ 124,685.11	\$ 129,672.51	\$ 134,859.41	\$ -	\$ -	\$ -
% 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)	\$ 124,685.11	\$ 129,672.51	\$ 134,859.41	\$ -	\$ -	\$ -
Other Housing Supports: Participant Assistant Funds (2)	\$ 124,685.11	\$ 129,672.51	\$ 134,859.41	\$ -	\$ -	\$ -
Other Housing Supports: Housing Transition Navigation Services and Housing Tenancy Sustaining Services (2)	\$ 124,685.11	\$ 129,672.51	\$ 134,859.41	\$ -	\$ -	\$ -
Other Housing Supports: Outreach and Engagement (2)	\$ 124,685.11	\$ 129,672.51	\$ 134,859.41	\$ -	\$ -	\$ -
Capital Development Projects	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Housing Flex Pool Expenditures (start-up expenditures)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
BHSA Innovative Housing Intervention Pilots and Projects	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
MHSA INN Projects	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Subtotal (auto-populated)	\$ 872,795.77	\$ 907,707.60	\$ 944,015.90	\$ -	\$ -	\$ -
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	\$ 124,685.11	\$ 188,736.46	\$ 193,330.79			
Total Housing Interventions Expenditures (auto-populated)	\$ 997,480.88	\$ 1,096,444.06	\$ 1,137,346.70			

Housing Interventions Populations to be Served	Year One	Year Two	Year Three
Total Housing Interventions Component Funds Dedicated to Chronically Homeless Population (5)	\$ 2,000,000.00	\$ 2,080,000.00	\$ 2,163,200.00
Total Housing Interventions Component Funds Dedicated to Serving Individuals with a SUD only (5)	\$ 124,685.11	\$ 129,672.51	\$ 134,859.41
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)	68.1%	67.9%	67.7%
Housing Interventions Component Funds Used for Outreach and Engagement (2) (auto-populated)	4.2%	4.2%	4.2%
Projected Individuals to be Served (Unduplicated)	Year One	Year Two	Year Three
Eligible Children/TAY (25 years and younger)	5	5	5
Eligible Adults/Older Adults	20	20	20
Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	Year One	Year Two	Year Three
MHSA "Encumbered" INN	\$ 183,680.76	\$ 183,680.76	\$ 183,680.76
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)	\$ 1,120,000.00	\$ 1,164,800.00	\$ 1,211,392.00						
Transfers into Full Service Partnership component from Local Prudent Reserve	\$ 69,199.07	\$ 71,967.04	\$ 74,845.72						
Total Estimated Full Service Partnership Funding Allocated (MHSA - Unspent Carryover Funds)	\$ 2,092,967.52	\$ 2,176,686.22	\$ 2,263,753.67						
Total Estimated Full Service Partnership Funding (BHSA + MHSA Funds)	\$ 3,282,166.00	\$ 3,413,453.00	\$ 3,549,991.00						
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	\$ 547,027.67	\$ 568,908.78	\$ 591,665.13	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
High Fidelity Wraparound	\$ 547,027.67	\$ 568,908.78	\$ 591,665.13	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Individual Placement and Support (IPS) Model of Supported Employment (2)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Assertive Field-Based Initiation for SUD Treatment Services	\$ 547,027.67	\$ 568,908.78	\$ 591,665.13	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Other mental health or supportive services not already captured above (e.g., outreach, other recovery-oriented services, peers, etc.): Please define	\$ 547,027.67	\$ 568,908.78	\$ 591,665.13	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

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)	\$ 1,120,000.00	\$ 1,164,800.00	\$ 1,211,392.00
Transfers into Behavioral Health Services and Support component from Local Prudent Reserve	\$ 69,199.07	\$ 71,967.04	\$ 74,845.72
Total Estimated Behavioral Health Services and Support Funding Allocated (MHSA - Unspent Carryover Funds)	\$ 2,093,689.48	\$ 2,177,437.06	\$ 2,264,534.54
Total Estimated Behavioral Health Services and Support Funding (BHSA + MHSA Funds)	\$ 3,282,888.00	\$ 3,414,204.00	\$ 3,550,772.00

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)	\$ 130,481.33	\$ 135,700.58	\$ 141,128.61		\$ -	\$ -	\$ -	\$ -	\$ -
Adult and Older Adult System of Care, Excluding Populations Identified in 5892(a)(1) and 5892(a)(2)-Non FSP	\$ 130,481.33	\$ 135,700.58	\$ 141,128.61	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Early Intervention Expenditures	\$ 1,600,000.00	\$ 1,664,000.00	\$ 1,730,560.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Coordinated Specialty Care for First Episode Psychosis	\$ 1,500,000.00	\$ 1,560,000.00	\$ 1,622,400.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
All Other EI Expenditures	\$ 100,000.00	\$ 104,000.00	\$ 108,160.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Outreach and Engagement	\$ 130,481.33	\$ 135,700.58	\$ 141,128.61	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Workforce Education and Training (WET)	\$ 130,481.33	\$ 135,700.58	\$ 141,128.61	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Dedicated BHSA WET funds	\$ 130,481.33	\$ 135,700.58	\$ 141,128.61
Dedicated MHSA WET funds	\$ -	\$ -	\$ -
Capital Facilities and Technological Needs (CFTN)	\$ 130,481.33	\$ 135,700.58	\$ 141,128.61
Dedicated BHSA CF/TN funds	\$ 130,481.33	\$ 135,700.58	\$ 141,128.61
Dedicated MHSA CF/TN funds	\$ -	\$ -	\$ -
BHSA Innovative BHSS Pilots and Projects	\$ -	\$ -	\$ -
MHSA INN Projects	\$ -	\$ -	\$ -
Subtotal (auto-populated)	\$ 2,252,406.65	\$ 2,342,502.92	\$ 2,436,203.03
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	\$ 130,481.33	\$ 135,700.58	\$ 141,128.61
Total Behavioral Health Services and Supports Expenditures (auto-populated)	\$ 2,382,887.98	\$ 2,478,203.50	\$ 2,577,331.64
Youth-Focused Early Intervention Expenditures	Year One	Year Two	Year Three
Total Youth-Focused (25 years and younger) Early Intervention Expenditures	\$ 900,000.00	\$ 936,000.00	\$ 973,440.00
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)	51.6%	51.5%	51.4%
Youth-Focused (25 years and younger) Early Intervention Expenditures/Total Allocated Early Intervention Funds (3)	56.3%	56.3%	56.3%
Projected Individuals to be Served (Unduplicated)	Year One	Year Two	Year Three
Eligible Children/TAY (25 years and younger)	195	195	195
Eligible Adults/Older Adults	458	458	458
Projected BHSS Funds transferred to WET or CF/TN	Year One	Year Two	Year Three
BHSS transfer to WET	\$ -	\$ -	\$ -
BHSS transfer to CF/TN	\$ -	\$ -	\$ -
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	\$ 705.01	\$ 705.01	\$ 705.01
Estimated MHSA CF/TN Funds	\$ 16.95	\$ 16.95	\$ 16.95
MHSA "Encumbered" INN	\$ 183,680.76	\$ 183,680.76	\$ 183,680.76
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	\$ 200,000.00	\$ 208,000.00	\$ 216,320.00
Total Projected County Integrated Plan Annual Planning Expenditures	\$ 20,000.00	\$ 20,800.00	\$ 21,632.00
New and Ongoing Administrative Costs	\$ 50,000.00	\$ 52,000.00	\$ 54,080.00
Select County Population Size:	Less than 200k		
Administrative Information Validation			
Total Projected Annual Revenues of Local Behavioral Health Services Fund	\$ 5,000,000.00	\$ 5,200,000.00	\$ 5,408,000.00
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)	0.4%	0.4%	0.4%
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	\$ 614,780.00
Local Prudent Reserve Maximum (1)	\$ 822,377.22
Excess Prudent Reserve Funds (auto-populated)	\$ (207,597.22)
Total prudent reserve funds above prudent reserve maximum allocated to Housing Interventions	\$ (69,199.07)
Total prudent reserve funds above maximum allocated to Full Service Partnerships	\$ (69,199.07)
Total prudent reserve funds above maximum allocated to Behavioral Health Services and Supports	\$ (69,199.07)

Total Excess Prudent Reserve Funds allocated to BHSA Component Allocations (auto-populated)	\$ (207,597.22)
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)	\$ 648,035.48
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	30%	35%	35%	100%
Component Allocations	\$ 960,000.00	\$ 1,120,000.00	\$ 1,120,000.00	\$ 3,200,000.00
Year Two				
Allocation Percentage, with Transfers	30%	35%	35%	100%
Component Allocations	\$ 998,400.00	\$ 1,164,800.00	\$ 1,164,800.00	\$ 3,328,000.00
Year Three				
Allocation Percentage, with Transfers	30%	35%	35%	100%
Component Allocations	\$ 1,038,336.00	\$ 1,211,392.00	\$ 1,211,392.00	\$ 3,461,120.00
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)	\$ 960,000.00	\$ 1,120,000.00	\$ 1,120,000.00	\$ 3,200,000.00
Transfers From PR Into Component	\$ 69,199.07	\$ 69,199.07	\$ 69,199.07	\$ 207,597.22
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds) (Unspent Carryover MHSA Funds)	\$ 2,092,967.52	\$ 2,092,967.52	\$ 2,093,689.48	\$ 6,279,624.51
Estimated Total Available Funding for Year One	\$ 3,122,166.59	\$ 3,282,166.59	\$ 3,282,888.55	\$ 9,687,221.73
Transfers from Component Into PR	\$ -	\$ -	\$ -	\$ -
Estimated Total Year One Expenditures	\$ 997,480.88	\$ 3,282,166.02	\$ 2,382,887.98	\$ 6,662,534.88
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)	\$ 998,400.00	\$ 1,164,800.00	\$ 1,164,800.00	\$ 3,328,000.00
Transfers From PR Into Component	\$ 71,967.04	\$ 71,967.04	\$ 71,967.04	\$ 215,901.11
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	\$ 4,301,371.93	\$ 2,176,686.79	\$ 3,077,437.63	\$ 9,555,496.34
Estimated Total Available Funding for Year Two	\$ 5,371,738.96	\$ 3,413,453.82	\$ 4,314,204.66	\$ 13,099,397.45
Transfers from Component Into PR	\$ -	\$ -	\$ -	\$ -
Estimated Total Year Two Expenditures	\$ 1,096,444.06	\$ 3,413,452.66	\$ 2,478,203.50	\$ 6,988,100.22
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)	\$ 1,038,336.00	\$ 1,211,392.00	\$ 1,211,392.00	\$ 3,461,120.00
Transfers From PR Into Component	\$ 74,845.72	\$ 74,845.72	\$ 74,845.72	\$ 224,537.15
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	\$ 6,539,048.57	\$ 2,263,754.83	\$ 4,100,535.70	\$ 12,903,339.10
Estimated Total Available Funding for Year Three	\$ 7,652,230.29	\$ 3,549,992.55	\$ 5,386,773.42	\$ 16,588,996.25
Transfers from Component Into PR	\$ -	\$ -	\$ -	\$ -

Estimated Total Year Three Expenditures	\$ 1,137,346.70	\$ 3,549,990.77	\$ 2,577,331.64	\$ 7,264,669.10
BHSA Plan Admin Expenses				
Plan Admin Category	Year One	Year Two	Year Three	Total
Total Projected Improvement and Monitoring Expenditures	\$ 200,000.00	\$ 208,000.00	\$ 216,320.00	\$ 624,320.00
Total Projected County Integrated Plan Annual Planning Expenditures	\$ 20,000.00	\$ 20,800.00	\$ 21,632.00	\$ 62,432.00
Total Projected New and Ongoing Administrative Expenditures	\$ 50,000.00	\$ 52,000.00	\$ 54,080.00	\$ 156,080.00

Budget Template Updates			
Version	Revision Date	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 Components): 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

Board of Supervisors Certification

Certification

1. Board of Supervisors certifies the following:
 - ☐ Board of Supervisors has reviewed and approved this Integrated Plan for the period of
 - ☐ County will meet its realignment obligations pursuant to W&I Code section 14197, including but not limited to time or distance standards and appointment time standards set forth in W&I Code section 14197 or other applicable guidance, without utilizing waitlists
2. Does the county wish to disclose any implementation challenges or concerns with these requirements?
 - ☒ Yes
 - ☐ No
- a. If answered yes above, please describe any implementation challenges or concerns with their realignment obligations (optional)

Signature

3. Printed name

4. Title

5. Date

6. Signature