COUNTY OF MARIN

DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Promoting and protecting health, well-being, self-sufficiency, and safety of all in Marin County.

MARIN HEALTH & HUMAN SERVICES
Health, Well-being & Safety

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APPROVED
DEC 09 2025
MARIN COUNTY
BOARD OF SUPERVISORS

AGENDA DATE: December 9, 2025

TO: Marin County Board of Supervisors

FROM: Lisa Warhuus, PhD

SUBJECT: Department of Health and Human Services (HHS), Division of Behavioral Health and Recovery Services (BHRS), requests approval of the FY 2026-27 – FY 2028-29 Behavioral Health Services Act (BHSA) Integrated Plan.

RECOMMENDATION:

1. Authorize your Board to approve the FY 2026-27 – FY 2028-29 Behavioral Health Services Act (BHSA) Integrated Plan.

SUMMARY: The Behavioral Health Services Act (BHSA) Integrated Plan details the proposed use over three years of $68,115,848 in BHSA funds for a broad range of community-based and County-operated behavioral health programs and services. This Integrated Plan is the first three-year plan under the Behavioral Health Services Act (BHSA) and marks the transition from the Mental Health Services Act (MHSA) to BHSA. The BHSA is part of the State's larger Behavioral Health Transformation efforts and represents a shift from prevention, intervention, and treatment across the behavioral health spectrum to focus on the most severe. The intent of the BHSA is to expand services to include treatment for those with substance use disorders and prioritize care for individuals with the most serious mental illness, including the disproportionate number experiencing homelessness.

Behavioral health priorities addressed in this plan include:

- Funding to support Full-Service Partnership programs including Assertive Community Treatment, Intensive Case Management, High Fidelity Wraparound, Individual Placement and Support, and Assertive Field-Based Substance Use Disorder

- Dedicated funding to support behavioral health Housing Interventions including Permanent Supportive Housing, rental subsidies, operating subsidies, capital development project, and housing interventions outreach and engagement

- Funding to support Behavioral Health Services and Supports such as recovery-oriented peer services, crisis residential, outreach to ensure

CABL

timely access to behavioral health services, and early intervention for children, youth, adults, older adults, veterans, and underserved cultural and geographic communities, and Coordinated Specialty Care for First Episode Psychosis.

The Department will return to your Board for approval of contracts with community-based organizations.

DISCUSSION/BACKGROUND: This BHSA Integrated Plan was developed with the participation of over 400 community members including individuals with personal lived experience with behavioral health challenges and individuals with lived experience as a family member of someone who has experienced behavioral health challenges. This involved approximately 30 community planning meetings, an ongoing MHSA Advisory Committee with diverse representation, and ongoing input from the Behavioral Health Board. Community planning meetings were offered across Marin County via in-person and virtual formats, day and evening, and weekdays and weekends. Focused meetings were held with individuals with lived experience, families, older adults, early childhood behavioral health providers, BHRS staff, and LGBTQ+ community members. Spanish interpretation was available in several meetings and four meetings were facilitated entirely in Spanish and one in Vietnamese. BHRS collected and incorporated data from a BHSA Survey, offered in English, Spanish, and Vietnamese, which provided community-ranked behavioral health priorities and detailed feedback on barriers to service. The survey was publicized through the Marin Independent Journal, social media including the Marin County Health and Human Service's Facebook, Instagram, and X accounts, and emailed widely. Paper versions of the survey were made available at events focused on reaching individuals experiencing homelessness and events focused on youth.

This BHSA Integrated Plan was informed by fourteen Department of Health Care Services (DHCS) -identified statewide behavioral health goals aimed at improving wellbeing (e.g., access to care), decreasing adverse outcomes (e.g., suicides, overdoses), and reducing disparities. Marin County is already making steady, data-informed progress toward these statewide behavioral health goals, showing strong performance in adult access to care, timely follow-up after emergency visits, and overall lower homelessness and institutionalization rates compared to statewide averages.. Persistent disparities, particularly affecting youth and residents who are Black, Latino, Asian American/Pacific Islander, or Native American, highlight areas for continued focus.

This Integrated Plan aligns with the 2025 Marin County Community Health Assessment (CHA) and the 2024-2026 Community Health Improvement Plan (CHIP). Specifically, access to care, overdoses, and suicides were identified as shared priorities in the CHA, CHIP, and the Integrated Plan. Through the combination of qualitative insights with quantitative data, BHRS conducted a thorough analysis to ensure identified behavioral health priorities in the

Integrated Plan reflect the needs of the community. This Integrated Plan represents a proactive approach to improve wellbeing, decrease adverse outcomes, and reduce disparities through the incorporation of equity-centered strategies, including field-based mental health and substance use services, culturally responsive outreach, and housing interventions.

POLICY FRAMEWORK: On June 10, 2025, your Board approved the final Mental Health Services Act (MHSA) FY 2025-26 Annual Update. This is the first Behavioral Health Services Act (BHSA) Integrated Plan. The State requires approval of the BHSA Integrated Plan by the County Board of Supervisors (W&I Code § 5963.02, subdivision [a][3]).

EQUITY IMPACT SUMMARY: The delivery of culturally-responsive and linguistically-appropriate behavioral health services is a core tenet of this Integrated Plan. This plan will provide funding for behavioral health services and programs which aim to reduce disparities identified through community planning, in the statewide behavioral health goals analysis, and in the 2025 Marin County Community Health Assessment and the 2024-2026 Community Health Improvement Plan.

COMMUNITY ENGAGEMENT: The draft BHSA Integrated Plan was posted for over thirty (30) days for public comment on the Marin County Behavioral Health and Recovery Services' webpage beginning on October 3, 2025, and continuing until November 4, 2025. The public comment period was advertised in the Marin Independent Journal and posted on social media including the Marin County Health and Human Service's Facebook, Instagram, and X accounts, and emailed widely. On Tuesday, November 4, 2025, the Behavioral Health Board hosted a public hearing. All input received has been considered, and adjustments made as appropriate and incorporated into the presented BHSA FY 2026-27 – FY 2028-29 Integrated Plan.

PERFORMANCE MEASURE(S): The BHSA requires counties to submit Behavioral Health Outcomes, Accountability, and Transparency Reports (BHOATRs) to DHCS on an annual basis. The BHOATR will report on implementation of the BHSA Integrated Plan, including behavioral health spending, service utilization, programmatic outcomes, and achievement of statewide behavioral health goals. Your Board will be required to attest that the BHOATR is complete and accurate before it is submitted to DHCS (W&I Code § 5963.04, subdivision [c]). The first BHOATR will cover FY 2026-27 and will be due January 30, 2029. Counties will submit a draft BHOATR for FY 2026-27 due January 30, 2028. This one-time draft submission will allow DHCS to provide technical assistance. Although the BHOATR template has not been finalized, DHCS has stated the template will mirror the BHSA Integrated Plan reporting requirements.

CONTRACT RENEWALS AND PERFORMANCE OUTCOMES: This section is not applicable.

CONTRACT RISKS: This section is not applicable.

CEQA ANALYSIS: This section is not applicable.

FISCAL, FACILITY, & STAFFING ANALYSIS: There will be no increase in General Fund Net County cost as a result of your Board's approval. The Department will work with the Office of the County Executive to establish the BHSA program baseline budgets in alignment with this Integrated Plan. The services and programs outlined in this BHSA plan will be funded by a combination of state BHSA funding (incoming revenue starting July 1, 2026), MHSA fund balance, and Medi-Cal revenue.

ALTERNATIVE: W&I Code § 5963.02, subdivision [a][3]) requires the BHSA Integrated Plan be approved by the Board of Supervisors. Your Board could direct staff to make revisions to the plan and return for approval at a later date.

APPROVED BY:

- County Executive [X] Yes or [ ] N/A
- Department of Finance [ ] Yes or [X] N/A
- County Counsel [ ] Yes or [X] N/A
- Human Resources [ ] Yes or [X] N/A

SUBMITTED BY:

Lisa Warhuus

Lisa Warhuus, PhD
Director

ATTACHMENTS:

Attachment #1 – 2026 – 2029 Integrated Plan

Attachment #2 – Board of Supervisors Certification

DHCS Approval: June 5, 2026

2026 - 2029 Integrated Plan

Marin County

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

General Information

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

General Information

County, City, Joint Powers, or Joint Submission
County

Entity Name
Marin County

Behavioral Health Agency Name
Marin County Department of Health & Human Services, Division of Behavioral Health & Recovery Services

Behavioral Health Agency Mailing Address
20 N. San Pedro Road, Suite 2030 San Rafael, CA 94903

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Substance Abuse and Mental Health Services Administration (SAMHSA) liaison

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Quality Assurance or Quality Improvement (QA/QI) lead

Name	Email address
Katie Smith	Katie.Smith@MarinCounty.gov

Medical Director

Name	Email address
Amit Rajparia, MD	Amit.Rajparia@MarinCounty.gov

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)	632
Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service	571
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	29
Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC-ODS plan	<11*

Criteria	Number of Children and Youth Under Age 21
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	20
Were chronically homeless or experiencing homelessness or at risk of homelessness	<11*
Were in the juvenile justice system	21
Have reentered the community from a youth correctional facility	<11*
Were served by the Mental Health Plan and had an open child welfare case	24
Were served by the DMC County or DMC-ODS plan and had an open child welfare case	<11*

Criteria	Number of Children and Youth Under Age 21
Have received acute psychiatric care	52

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	654
Received Medi-Cal SMHS	2111
Received DMC or DMC-ODS services	1140
Received MH and SUD services from the MHP and DMC county or DMC-ODS plan	243
Were chronically homeless, or experiencing homelessness, or at risk of homelessness	540

Criteria	Number of Adults and Older Adults
Experienced unsheltered homelessness	49
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	15
Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing	42
Were in the justice system (on parole or probation and not currently incarcerated)	55
Were incarcerated (including state prison and jail)	146
Reentered the community from state prison or county jail	55
Received acute psychiatric services	228

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

Admitted or detained for 72-hour evaluation and treatment rate

216

Admitted for 14-day and 30-day periods of intensive treatment
0

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
1382

Please report the total population enrolled in DSH community solution projects (e.g., community-based restoration and diversion programs)
<11*

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
FY23/24 BHRS Electronic Health Records data, FY23/24 Marin County Jail booking data, FY23/24 LPS data from receiving facilities was used to complete the above section. Questions regarding homelessness could not be answered from BHRS Electronic Health Record given it does have some of the categories requested above and we cannot differentiate between such categories as Experienced unsheltered homelessness, Moved from unsheltered homelessness to being sheltered, Moved from unsheltered homelessness to being sheltered. Marin is examining solutions to address how this data is captured in the EHR. COC data was used to complete the homelessness categories above, utilizing an average of Marin County's PIT Count Rate of People Experiencing Homelessness with Severe Mental Illness and PIT Count Rate of People Experiencing Homelessness with Substance Use Disorder to estimate the number of adults. Data regarding clients who were part of the justice system is not comprehensive.

The planning process was informed by quantitative and qualitative data sources including Marin County's performance on statewide behavioral health goals, FY23/24 data on individuals served by BHRS, and community-identified behavioral health priorities gathered through ongoing stakeholder input, planning meetings, and surveys. Additional sources included the Marin County Community Health Improvement Plan 2024–2026, the 2025 Marin County Community Health Assessment, the Partnership HealthPlan of California 2025 Population Needs Assessment for Marin County, and outcomes reported in the FY25/26 Mental Health Services Act Annual Update.

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

Local CARE Act Implementation

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

CARE Act participants in Marin County are prioritized for placement within county-operated Full-Service Partnership (FSP) teams, which serve as the primary service delivery model for individuals with the highest behavioral health needs. These multidisciplinary teams provide intensive, wraparound services, including psychiatric care, case management, substance use treatment, and linkages to physical health and social supports.

To address housing instability, CARE participants are also prioritized for Behavioral Health Bridge Housing and other available supportive housing resources, ensuring alignment with the County's Housing First approach.

The County ensures priority access and specialized coordination through a dedicated CARE clinical team that works in close partnership with FSP providers. This includes standing, multidisciplinary case conferences to coordinate care transitions, expedite service linkage, and address barriers in real time. CARE participants are systematically tracked within the behavioral health system to ensure timely access to services and ongoing monitoring of engagement and outcomes. This coordinated approach ensures that CARE participants receive seamless, individualized care across the behavioral health continuum.

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

Marin County has integrated CARE Act referral pathways into its existing behavioral health access and service delivery infrastructure to ensure a streamlined and coordinated system of care. As a statewide "CARE Champion," Marin has demonstrated leadership in implementing efficient, accessible referral processes and maintaining one of the highest per-capita participation rates during the first year of statewide implementation.

CARE referrals are aligned with existing entry points, including the County's behavioral health access line, crisis services, outreach teams, and provider networks. The CARE clinical team works collaboratively with these partners to triage referrals, determine eligibility, and coordinate next steps without duplication or fragmentation of services.

A key feature of this integration is the County's emphasis on proactive, sustained outreach and engagement. The CARE clinical team partners with FSP providers through regular case conferences and shared care planning processes to ensure individuals are connected to appropriate services as quickly as possible. This integration reduces delays in care and ensures individuals entering through CARE pathways experience the same coordinated, person-centered continuum as those entering through traditional behavioral health channels.

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.

Marin County utilizes a robust screening, outreach, and engagement process during the Petition and Investigation phase to identify individuals who may be more appropriately served through voluntary or alternative service pathways rather than formal CARE Court proceedings.

The CARE clinical team conducts comprehensive outreach and engagement with all referred individuals, often over an extended period, to assess needs, build trust, and offer voluntary service options. A number of individuals ultimately accept services without requiring a formal CARE petition or court-ordered plan, reflecting the effectiveness of this engagement-first approach.

When individuals are redirected, the CARE clinical team facilitates warm handoffs to appropriate services. Successful linkage is confirmed through direct communication with receiving providers, participation in multidisciplinary case conferences, and documentation within the County's CARE tracking systems. Outreach attempts, engagement activities, and service connections are systematically recorded throughout the process.

For individuals transitioning into a CARE Agreement or CARE Plan, formal treatment conferences are held with the FSP team and the participant to ensure continuity of care and shared understanding of service goals. This structured yet flexible approach ensures that all individuals—regardless of CARE Court involvement—are connected to appropriate services and that those connections are actively monitored and documented.

County Behavioral Health Technical Infrastructure

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

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

Please select which of the following EHRs the county uses
SmartCare

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

Please select which QHIO the county participates in
Connex
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.marinbhrs.org/clients-caregivers/api-application-programming-interface

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
Children's System of Care Set-Aside
Discretionary/Base Allocation
First Episode Psychosis Set-Aside

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
Perinatal Set-Aside
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?
Yes

Please check all set asides the county behavioral health system participates in under OSF Exhibit E
Connect People Who Need Help to The Help They Need (Connections to Care)
First Responders
Leadership, Planning, and Coordination
Prevent Misuse of Opioids
Prevent Overdose Deaths and Other Harms (Harm Reduction)
Support People in Treatment and Recovery
Treat Opioid Use Disorder (OUD)

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?
Clubhouse Services
CSC for FEP
IPS Supported Employment

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 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

Recovery Incentives Program (Contingency Management)

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
No

Other Programs and Services

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

Program or service
N/A

Care Transitions

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

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

Statewide Behavioral Health Goals

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

Population-Level Behavioral Health Measures

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

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

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

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

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

Mark page as complete

Priority statewide behavioral health goals for improvement

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

Access to care: Primary measures

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

How does your county status compare to the statewide rate?

For adults/older adults
Above

For children/youth
Below

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

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

How does your county status compare to the statewide rate?

For adults/older adults
Above

For children/youth
Above

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

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

How does your county status compare to the statewide rate?

For adults/older adults
Not Applicable

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?

For adults/older adults
Above

For children/youth
Below

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

Access to care: Supplemental Measures

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

How does your county status compare to the statewide rate?
Below

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Access to care: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Marin was below the county-level rates among Asian American/Pacific Islander, Latino, and American Indian/Alaska Native adults and adults ages 21-44 with regard to Specialty Mental Health Services (SMHS) penetration rates. The Marin County Non-Specialty Mental Health Service (NSMHS) penetration rate was below the county-level rates among Asian American/Pacific Islander adults. Initiation of Substance Use Disorder Treatment indicated Marin was below the Statewide rate. Marin DMC-ODS Penetration Rates showed the penetration rates among Latino and Asian/Pacific Islander groups fell below county-level rates.

With regard to Access to Care for children and youth, Marin County was below the Statewide rate with regard to SMHS Penetration Rates for Children and Youth. Additionally, SMHS rates for Marin were below county-level rates for males, American Indian/Alaska Native, Asian American/Pacific Islander, and Latino children and youth and for ages 0-11. NSMHS rates for Marin were below the county-level rates among males, Black/African American and Asian American/Pacific Islander children and youth, and for ages 6-11. DMC-ODS penetration rate for children and youth indicated Marin County was below the Statewide rate.

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

Planning was informed by quantitative and qualitative data including Marin's performance on statewide behavioral health goals; FY23/24 BHRS Electronic Health Records; community-identified behavioral health priorities gathered through ongoing stakeholder input, planning meetings, and surveys; Marin County 2024–2026 CHIP; Marin County 2025 CHA, Partnership HealthPlan 2025 Marin County PNA; and FY25/26 MHSA Annual Update outcomes.

• Strengthen outreach and engagement efforts that move beyond awareness-building to ensure identified individuals are directly connected to SMHS treatment through warm hand-offs and closed-loop referral systems.
• Expand place-based services in West and South Marin to increase access to treatment
• Capitalize on new Assertive Field-Based Substance Use Disorder services to meet clients where they are to provide on-the-spot assessments and immediate linkage to care
• Partner with MCPs to develop pathways for MCPs to identify and refer members needing specialty mental health or SUD treatment
• Housing interventions outreach and engagement to utilize transitional housing, shelters, and supportive housing as touchpoints for behavioral health screening and treatment linkage
• Partner with CBOs to expand behavioral health outreach, screenings, treatment, and support closed-loop referrals
• Strengthen outreach and engagement efforts that move beyond awareness-building to ensure identified individuals are directly connected to SMHS treatment through warm hand-offs and closed-loop referral systems.
• Strengthen adolescent SUD treatment services through new Assertive Field-Based Substance Use Disorder services to meet clients where they are to provide on-the-spot assessments and immediate linkage to care
• Partner with MCPs to develop pathways for MCPs to identify and refer members needing specialty mental health or SUD treatment
• Partner with CBOs to expand early intervention outreach, screenings, treatment, and support closed-loop referrals

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

BHSA Behavioral Health Services and Supports (BHSS)
2011 Realignment
Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS)

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?
Below

What disparities did you identify across demographic groups or special populations?
Age
Sex
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?
Race or Ethnicity

Homelessness: Supplemental Measures

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

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

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

PIT Count Rate of People Experience Homelessness with Chronic Substance Abuse, (Rate per 10,000 people by Continuum of Care Region) (HUD), 2024

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

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

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

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

What disparities did you identify across demographic groups or special populations?
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
Adults ages 18-44, males, and Native Hawaiian/Pacific Islander, Black/African American, Latino, and American Indian/Alaska Native groups were overrepresented in the Point-In-Time Count Rate of People Experiencing Homelessness. According to the CA Department of Education Housing Status of K-12 students, Latino students in Marin were overrepresented in the number of students experiencing homelessness with the majority identified as having a housing status as "temporarily doubled up." Males, individuals under the age of 18, ages 25-44, and Black/African American, American Indian/Alaska Native, Native Hawaiian/Pacific Islander, and Latino groups were more likely to access CoC services.

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)

Planning was informed by quantitative and qualitative data including Marin's performance on statewide behavioral health goals; FY23/24 BHRS Electronic Health Records; community-identified behavioral health priorities gathered through ongoing stakeholder input, planning meetings, and surveys; Marin County 2024–2026 CHIP; Marin County 2025 CHA, Partnership HealthPlan 2025 Marin County PNA; and FY25/26 MHSA Annual Update outcomes.

• Housing interventions outreach and engagement to utilize transitional housing, shelters, and supportive housing as touchpoints for behavioral health screening and treatment linkage. Supported by BHSA funding.

• Partner with MCPs to connect unhoused or housing-unstable clients to ECM and housing-related Community Supports. Supported by BHSA funding.

• Partner with Community Resiliency Teams to increase successful navigation of access points to behavioral health and housing services.

• Partner with Homelessness and Coordinated Care to both strengthen outreach and engagement and to identify and prioritize clients with unmet behavioral health needs.

• Strengthen Behavioral Health Bridge Housing services with the goal of improving permanent housing, recovery, and behavioral health outcomes.

• Pair bilingual/bicultural peers with homeless outreach teams in high-volume service areas (shelters, encampments, food distribution sites) to provide on-the-spot screening, harm reduction services, and referrals. Supported by BHSA funding

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

BHSA FSP
BHSA Housing Interventions
1991 Realignment
MHBG

Institutionalization

Per 42 CFR 435.1010, an institution is "an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor." Institutional settings are intended for individuals with conditions including, but not limited to, behavioral health conditions.
Care provided in inpatient and residential (i.e., institutional) settings can be clinically appropriate and is part of the care continuum. Here, institutionalization refers to individuals residing in these settings longer than clinically appropriate. Therefore, the goal is not to reduce stays in institutional settings to zero. The focus of this goal is on reducing stays in institutional settings that provide a Level of Care that is not – or is no longer – the least restrictive environment. (no action)

Institutionalization: Primary Measures

Inpatient administrative days (DHCS) rate, FY 2023

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

For adults/older adults
Not Applicable

For children/youth
Not Applicable

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Institutionalization: Supplemental Measures

Involuntary Detention Rates, FY 2021 - 2022

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

14-day involuntary detention rates per 10,000
Below

30-day involuntary detention rates per 10,000
Above

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

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Conservatorships, FY 2021 - 2022

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

Temporary Conservatorships
Same

Permanent Conservatorships
Below

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

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

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

Crisis Intervention

For adults/older adults
Below

For children/youth
Below

Crisis Residential Treatment Services

For adults/older adults
Below

For children/youth
Not Applicable

Crisis Stabilization

For adults/older adults
Above

For children/youth
Below

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity
Sex

Institutionalization: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Marin County was higher than Statewide SMHS Crisis Stabilization and 30-Day Involuntary Detention rates. When compared to county-level rates, Marin had higher Crisis Intervention rates among adults ages 45-56, 69+ and White individuals. Crisis Stabilization youth rates were higher among males, ages 18-20, and Black and Latino groups. Compared to county-level rates, Marin had higher Crisis Stabilization rates among adults ages 69+.

Institutionalization: Cross-Measure Questions

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

Measures where Marin County's performance is below the statewide average, include 14-day involuntary detention rates, the number of permanent conservatorships, and utilization of crisis services such as adult and older adult crisis intervention, crisis residential treatment, and child/youth crisis stabilization. Local data indicate opportunities to strengthen early intervention and community-based crisis response, reducing reliance on institutional and involuntary care. Planned initiatives directly address these gaps by strengthening crisis supports and improving access to care in the least restrictive settings. These priorities, developed through community planning and stakeholder engagement, emphasize early intervention, voluntary crisis options such as peer-led respite program, and coordinated responses designed to stabilize individuals in the community and prevent escalation to higher levels of care.

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

Planning was informed by quantitative and qualitative data including Marin's performance on statewide behavioral health goals; FY23/24 BHRS Electronic Health Records; community-identified behavioral health priorities gathered through ongoing stakeholder input, planning meetings, and surveys; Marin County 2024–2026 CHIP; Marin County 2025 CHA, Partnership HealthPlan 2025 Marin County PNA; and FY25/26 MHSA Annual Update outcomes.

• Early intervention to support individuals experiencing a behavioral health crisis (e.g., warm lines, support groups, drop-in centers, Community Resiliency Teams)
• Strengthen Mobile Crisis Response Team and Crisis Aftercare Team to reduce need for stabilization and/or residential
• Develop voluntary, short-term, peer respite option for individuals in crisis. Ensure respite centers are connected to warm lines, MCRT, and outpatient behavioral health programs.

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Please identify the category or categories of funding that the county is using to address the institutionalization goal
BHSA BHSS
BHSA FSP
BHSA Housing Interventions
1991 Realignment
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)

Justice-Involvement: Primary Measures

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

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

For adults/older adults
Below

For juveniles
Above

What disparities did you identify across demographic groups or special populations?
Race or Ethnicity
Sex
Age

Justice-Involvement: Supplemental Measures

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

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

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

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

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

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Justice-Involvement: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Adults ages 20-39, Black/African American, Latino, and males were overrepresented in both felony and misdemeanor arrests in Marin County. Similarly, Black/African American, Latino, and male juveniles were overrepresented in felony and misdemeanor arrests in Marin County.

Justice-Involvement: Cross-Measure Questions

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

behavioral health goals; FY23/24 BHRS Electronic Health Records; community-identified behavioral health priorities gathered through ongoing stakeholder input, planning meetings, and surveys; Marin County 2024–2026 CHIP; Marin County 2025 CHA, Partnership HealthPlan 2025 Marin County PNA; and FY25/26 MHSA Annual Update outcomes.
• Utilize CalAIM funding streams to provide Enhanced Care Management (ECM), Community Supports, and case management for individuals leaving jail or prison.
• Ensure justice-involved individuals are connected to specialty mental health and SUD treatment immediately upon release.
• Create partnerships with probation, MCPs, and CBOs to expand behavioral health screenings and support closed-loop referrals
• New expansion of Crisis Intervention Training with emphasis on implicit bias
• Partner with Community Resiliency Teams to increase successful navigation of access points to behavioral health and housing services
• Strengthen early intervention services for youth and young adults (ages 16–25) at risk of arrest, including behavioral health supports
• Improve language access in reentry and jail-based services. Ensure all screening, treatment, and case management services in jail are linguistically and culturally appropriate. Translate reentry planning materials/packets, peer navigation resources, and community referrals.

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Please identify the category or categories of funding that the county is nusing to address the justice-involvement goal
BHSA BHSS
BHSA FSP
2011 Realignment
Federal Financial Participation (SMHS, DMC/DMC-ODS)

Removal Of Children from Home: Primary Measures

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

How does your county status compare to the statewide rate?
Below

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

Removal Of Children from Home: Supplemental Measures

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

How does your county status compare to the statewide rate?
Below

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity
Sex

Child Maltreatment Substantiations (CWIP), 2022

How does your county status compare to the statewide rate?
Below

What disparities did you identify across demographic groups or special populations?
None Identified

Removal Of Children from Home: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Open Child Welfare Case SMHS Penetration Rates revealed lower rates for Marin County in comparison to Statewide rates and county-level rates with regard to White, Latino, female, and youth ages 0-5 and 18-20. Moreover, Latino children were overrepresented in the Point in Time/In Care Counts of children in foster care.

Removal Of Children from Home: Cross-Measure Questions

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

Planning was informed by quantitative and qualitative data including Marin's performance on statewide behavioral health goals; FY23/24 BHRS Electronic Health Records; community-identified behavioral health priorities gathered through ongoing stakeholder input, planning meetings, and surveys; Marin County 2024–2026 CHIP; Marin County 2025 CHA, Partnership HealthPlan 2025 Marin County PNA; and FY25/26 MHSA Annual Update outcomes.

• Strengthen referral pathway between Marin Children and Family Services Family Preservation and BHRS to provide behavioral health supports to prevent a case from being opened

• Formalize referral pathways so that Marin Child & Family Services (CFS) consistently refers families with open child welfare cases to BHRS

• Enroll eligible children and families in ECM to improve care coordination between CFS, BHRS, and MCPs. Leverage CalAIM housing and family stabilization supports for child welfare–involved families at risk of homelessness.

• Strengthen trauma-informed, culturally responsive, and linguistically appropriate parenting groups. Incorporate lived-experience family partners who can support parents navigating both CFS and BHRS.

• Ensure early childhood early intervention programs assess for neglect and maltreatment. Strengthen closed-loop referral systems.

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

BHSA BHSS
BHSA FSP
2011 Realignment
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)
MHBG

Untreated Behavioral Health Conditions: Primary Measures

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

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

For the full population measured
Above

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

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

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

For the full population measured
Above

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Untreated Behavioral Health Conditions: Supplemental Measures

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

How does your county status compare to the statewide rate?

For the full population measured
Below

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Untreated Behavioral Health Conditions: Disparities Analysis

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

Untreated Behavioral Health Conditions: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of untreated behavioral health conditions. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)
Planning was informed by quantitative and qualitative data including Marin's performance on statewide behavioral health goals; FY23/24 BHRS Electronic Health Records; community-identified behavioral health priorities gathered through ongoing stakeholder input, planning meetings, and surveys; Marin County 2024–2026 CHIP; Marin County 2025 CHA, Partnership HealthPlan 2025 Marin County PNA; and FY25/26 MHSA Annual Update outcomes.

- Strengthen outreach and engagement efforts that move beyond awareness-building to ensure identified individuals are directly connected to SMHS treatment through warm hand-offs and closed-loop referral systems.
- Capitalize on new Assertive Field-Based Substance Use Disorder services to meet clients where they are to provide on-the-spot assessments and immediate linkage to care
- Partner with CBOs to expand early intervention outreach, screenings, treatment, and support closed-loop referrals

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Please identify the category or categories of funding that the county is using to address the untreated behavioral health conditions goal
BHSA BHSS
BHSA FSP

Additional statewide behavioral health goals for improvement

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

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

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

Care Experience: Primary Measures

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

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

For adults/older adults
Same

For children/youth
Above

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

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

For adults/older adults
Above

For children/youth
Above

Engagement In School: Primary Measures

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

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

Engagement In School: Supplemental Measures

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

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

Student Chronic Absenteeism Rate (Data Quest), 2022

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

Engagement In Work: Primary Measures

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

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

Engagement In Work: Supplemental Measures

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

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

Overdoses: Primary Measures

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

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

For the full population measured
Below

For adults/older adults
Above

For children/youth
Below

Overdoses: Supplemental Measures

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

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

For the full population measured
Above

For adults/older adults
Above

For children/youth
Above

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

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

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

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

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

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

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

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

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

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

Quality Of Life: Primary Measures

Perception of Functioning Domain Score (CPS), 2024

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

For the full population measured
Same

For adults/older adults
Same

For children/youth
Same

Quality Of Life: Supplemental Measures

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

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

For the full population measured
Below

Social Connection: Primary Measures

Perception of Social Connectedness Domain Score (CPS), 2024

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

For the full population measured
Same

For adults/older adults
Same

For children/youth
Same

Social Connection: Supplemental Measures

Caring Adult Relationships at School (CHKS), 2023

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

Suicides: Primary Measures

Suicide Deaths, 2022

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

For the full population measured
Above

Suicides: Supplemental Measures

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

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

For the full population measured
Below

For adults/older adults
Above

For children/youth
Above

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.
Overdoses
Suicides

Overdoses

Please describe why this goal was selected
This goal was selected given the growing importance of reducing overdoses in Marin County. Overdoses, and substance use services in general, were identified as priorities in community planning feedback and in the most recent Marin County Community Health Assessment.

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
Marin County had a higher All Drug-Related Overdose ED Visits rate compared to the State. Compared to county-level rates, Marin had higher All Drug-Related Overdose ED Visits rates for males; ages < 5, 10-29, 30-39; and for White, Latino, and Black/African American individuals. Marin also had higher All Drug-Related Overdose Deaths for males; ages 30-44, 50-74; and for White and Black/African American individuals.

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 Overdoses 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)

Planning was informed by quantitative and qualitative data including Marin's performance on statewide behavioral health goals; FY23/24 BHRS Electronic Health Records; community-identified behavioral health priorities gathered through ongoing stakeholder input, planning meetings, and surveys; Marin County 2024–2026 CHIP; Marin County 2025 CHA, Partnership HealthPlan 2025 Marin County PNA; and FY25/26 MHSA Annual Update outcomes.

• Capitalize on new Assertive Field-Based Substance Use Disorder services to connect TAY and older adults with on-the-spot assessments, mobile MAT initiation, naloxone distribution, and low-barrier treatment entry to care

• Strengthen partnerships with Marin County Aging and Adult Services and trusted, culturally responsive CBOs to engage impacted populations. Coordinate overdose prevention, surveillance, and harm reduction strategies with LHJ.

• Strengthen partnership with OD Free Marin, the countywide collaborative focused on reducing overdoses, to improve rates of ED visits for all drug-related overdoses. Specific strategies include supporting efforts to increase MAT prescriber capacity, promoting the availability of substance use prevention, harm reduction and treatment services, and address stigma related to substance use and MAT access.

• Suicide Overdose Fatality Review process allows County behavioral health and public health departments and local mental health, substance use/addiction, and medical providers to track near real-time trends, determine which populations in Marin are most at risk, and consider systemic changes that could potentially prevent future suicides and overdose related deaths

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

BHSA BHSS
2011 Realignment
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)
SUBG
Other
BHSA FSP

Please describe other

Opioid Settlement Funds

Suicides

Please describe why this goal was selected

Suicide reduction has long been a goal of Marin County. Reducing suicides was identified as priorities in community planning feedback and in the most recent Marin County Community Health Assessment.

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

Marin County had a higher death by suicide rate compared to the Statewide rate. Compared the county-level rate, Marin had a higher death by suicide rate for males. Marin County higher non-fatal self-harm injury ED visit rates among individuals aged 10-44, females, and Black/African American and Latino individuals in comparison to the county-level rate. Additional analysis of EpiCenter California Injury Data Online Dashboard data found that Marin had higher non-fatal self-harm injury ED visit rates due to drug poisoning for individuals ages 10-25 when compared to the county-level rate.

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may improve your county's level of Suicides and refer to any data that was used to make this decision (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

Planning was informed by quantitative and qualitative data including Marin's performance on statewide behavioral health goals; FY23/24 BHRS Electronic Health Records; community-identified behavioral health priorities gathered through ongoing stakeholder input, planning meetings, and surveys; Marin County 2024–2026 CHIP; Marin County 2025 CHA, Partnership HealthPlan 2025 Marin County PNA; and FY25/26 MHSA Annual Update outcomes.

- Early identification and linkage of individuals experiencing initial signs of suicidality or related behavioral health concerns
- Groups for individuals with suicidal ideation and/or prior attempt
- Strengthen Crisis Aftercare Team to offer outreach to people discharged from the ED following self-harm
- Target intentional and nonintentional drug overdoses through strategies that may include new Assertive Field-Based Substance Use Disorder services for youth and TAYs
- Increase access to and awareness of MAT for the youth and TAY population through partnership with OD Free Marin
- Partner with schools to expand school-based substance use prevention education
- Suicide Overdose Fatality Review process allows County behavioral health and public health departments and local mental health, substance use/addiction, and medical providers to track near real-time trends, determine which populations in Marin are most at risk, and consider systemic changes that could potentially prevent future suicides and overdose related deaths

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

BHSA BHSS
BHSA FSP
Federal Financial Participation (SMHS, DMC/DMC-ODS)

Other

Please describe other
Opioid Settlement Funds

Community Planning Process

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

Stakeholder Engagement

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

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

County outreach through social media
County outreach through townhall meetings
County outreach through traditional media (e.g., television, radio, newspaper)
Meeting(s) with county
Public e-mail inbox submission
Survey participation
Training, education, and outreach related to community planning
Workgroups and committee meetings

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

Type of engagement
County outreach through social media

Date
1/9/2025

Type of engagement
County outreach through townhall meetings

Date
11/14/2024

Type of engagement
County outreach through traditional media (e.g., television, radio, newspaper)

Date
5/11/2025

Type of engagement
Training, education, and outreach related to community planning

Date
10/24/2024

Type of engagement
Survey participation

Date
11/14/2024

Type of engagement
Meeting(s) with county

Date
3/26/2024

Type of engagement
Public e-mail inbox submission

Date
10/24/2024

Type of engagement
Workgroups and committee meetings

Date
5/15/2024

Please list specific stakeholder organizations that were engaged in the planning process. Please do not include specific names of individuals
Aging Action Initiative, Bay Area Community Resources, Buckelew, Canal Alliance, Children and Family Services, Coastal Miwok Tribal Council of Marin, College of Marin, Commission on Aging, Empowerment Clubhouse, Enterprise Resource Center, Felton Institute, First 5, Golden Gate Regional Center, Healthy Marin Partnership, Huckleberry, Jewish Family Services, Kaiser, Marin 9 to 5, Marin Community Clinics, Marin County Aging and Adult Services, Marin County Alcohol and Drug Advisory Board, Marin County Behavioral Health Board, Marin County Cooperation Team, Marin County Homelessness and Coordinated Care, Marin County labor organizations (MAPE, MCMEA), Marin County Office of Education, Marin County Probation, Marin County Public Health, Marin County Sheriff's Office, Marin County Social Services, Marin County Veterans Services, Marin Multicultural Center, MHSA Advisory Committee, NAMI, North Marin Community Services, OD Free Marin, Partnership Health Plan, San Rafael Police Department, Sutter Health, West Marin Multi-Services Center

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

	City name
1	San Rafael
2	Novato
3	Mill Valley
4	San Anselmo

	City name
5	Larkspur

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

Please describe and provide documentation (such as meeting minutes) to support how diverse stakeholder viewpoints were incorporated into the development of the Integrated Plan, including any community-identified strengths, needs, and priorities
Marin County employed a comprehensive and inclusive approach to community engagement in the development of the BHSA Integrated Plan. Broad, ongoing input from diverse community stakeholders served as a foundation for shaping the plan. In addition, Marin County convened multiple community planning meetings, with feedback documented and organized in an Excel database for review. ChatGPT was utilized to explore qualitative feedback collected from the planning meetings, as well as from continuous stakeholder engagement efforts and a dedicated Opioid Settlement Fund Listening Session with youth participants.

Furthermore, Marin County collected and incorporated data from a BHSA Survey, offered in English, Spanish, and Vietnamese, which provided community-ranked behavioral health priorities and detailed feedback on barriers to service. By combining qualitative insights with quantitative survey results, Marin conducted a thorough analysis to ensure that identified behavioral health priorities truly reflect the voices, experiences, and needs of the community.

Upload File
BHSA Community Planning Process Demographics and Feedback.pdf

Local Health Jurisdiction (LHJ)

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

Did the county work with its LHJ on the development of the LHJ's recent Community Health Assessment (CHA) and/or Community Health Improvement Plan (CHIP) **? Additional**

information regarding engagement requirements with other local program planning processes can be found in Policy Manual Chapter 3, Section B.2.3.
Yes

Please describe how the county engaged with LHJs, along with Medi-Cal managed care plans **(MCPs), across these three areas in developing the CHA and/or CHIP: collaboration, data-sharing, and stakeholder activities**
Collaborative engagement occurs through bi-weekly Healthy Marin Partnership CHA/CHIP subcommittee meetings. Behavioral Health Goal data was shared to inform the development of the CHIP. Collaborative stakeholder activities occurs through identification of shared stakeholders; co-hosting community events; coordinating messaging on the development of the IP, CHA, and CHIP; and sharing BHSA community stakeholder engagement feedback to inform the development of the CHIP.

Did the county utilize the County-LHJ-MCP Collaboration Tool provided via technical assistance?
No

Collaboration

Please select how the county collaborated with the LHJ
Attended key CHA and CHIP meetings as requested.
Served on CHA and CHIP governance structures and/or subcommittees as requested.

Data-Sharing

Data-Sharing to Support the CHA/CHIP

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

Was data shared?
Yes

Data-Sharing from MCPS and LHJs to Support IP development

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

Was data shared?
Yes

Stakeholder Activities

Select which stakeholder activities the county has coordinated for IP development with the LHJ engagement on the CHA/CHIP. Please note that although counties must coordinate stakeholder activities with LHJ CHA/CHIP processes (where feasible), the options below are for illustrative purposes only and are not required forms of stakeholder activity coordination (e.g., counties do not need to conduct each of these activities)
Collaborated with LHJ to identify shared stakeholders that are key for both the IP and CHA/CHIP process.
Co-hosted community sessions, listening tours, and/or other community events that can be used to strengthen stakeholder engagement for both the IP and CHA/CHIP.
Coordinated messaging and stakeholder events calendars (e.g., governance meetings) around IP development and CHA/CHIP engagement.

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

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

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

Access to mental health and substance use services were consistently identified as needs in the Marin County Community Health Assessment (CHA). The Key Indicators listed in the CHA align with the input received in community planning and statewide behavioral health goals and their associated measures. Overdose Prevention is the number one priority followed by Access to Care in the 2024 – 2026 Marin Community Health Improvement Plan.

Medi-Cal Managed Care Plan (MCP) Community Reinvestment

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

Please list the Managed Care Plans (MCP) the county worked with to inform the MCPs' respective community reinvestment planning and decision-making processes

Kaiser and Partnership HealthPlan of California

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

Kaiser does not submit a Community Reinvestment Plan, however, makes alternative investments in the community. Marin will collaborate with Partnership HealthPlan on MCP Community Reinvestment activities that address identified behavioral health needs.

Comment Period and Public Hearing

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

Comment Period and Public Hearing

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

Confirm that the data is up to date and reflects the correct information for a Final Plan

Date the draft Integrated Plan (IP) was released for stakeholder comment
10/3/2025

Date the stakeholder comment period closed
11/4/2025

Date of behavioral health board public hearing on draft IP
11/4/2025

Please provide proof of a public posting with information on the public hearing. Please select the county's preferred submission modality
PDF,image,or other document

Please upload the PDF, image, or other file documenting the public posting
BHSA Public Comment and Hearing HHS Socials 4.pdf
BHSA Public Comment and Hearing HHS Socials 3.pdf
Marin Independent Journal BHSA Legal Notice.pdf
BHSA Public Comment and Hearing HHS Socials 2.pdf
BHSA Public Comment and Hearing HHS Socials 1.pdf

If the county uses an existing landing page or other web-based location to publicly post IPs for comment, please provide a link to the landing page
https://MarinBHRS.org/MHSA

File Upload
BHSA Public Comment and Hearing Screenshot.pdf

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

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

Stakeholder group that provided feedback
anonymous online submission

Summarize the substantive revisions recommended this stakeholder during the comment period
Support to provide funding for housing vouchers

Stakeholder group that provided feedback
anonymous online submission

Summarize the substantive revisions recommended this stakeholder during the comment period
Concern over the potential impact of decreased funding on culturally competent and bilingual behavioral health services to the Latino community in the Canal

BHRS Response: Early identification and engagement of individuals from underserved cultural and geographic communities and increased access to culturally and linguistically responsive behavioral health services are included in the BHSA Integrated Plan.

Stakeholder group that provided feedback
anonymous online submission from family member of individual with lived experience

Summarize the substantive revisions recommended this stakeholder during the comment period
Support for housing intervention and for BHSA Integrated Plan in general

Stakeholder group that provided feedback
anonymous online submission

Summarize the substantive revisions recommended this stakeholder during the comment period
Concern over gap between outpatient and crisis services and lack of day treatment options which could fill the gap and prevent crisis services or the ED from being overutilized.

BHRS Response: Early identification and engagement of individuals experiencing a behavioral health crisis are included in the BHSA Integrated Plan. Also included in the Plan, BHRS will create a peer respite option to minimize crisis services from being overutilized.

Stakeholder group that provided feedback
NAMI Marin

Summarize the substantive revisions recommended this stakeholder during the comment period
Ensure funding is available for family support.

BHRS Response: Strengthening support for family members is included in the BHSA Integrated Plan.

Stakeholder group that provided feedback
Marin County Commission on Aging Health

Summarize the substantive revisions recommended this stakeholder during the comment period
Ensure funding address the mental health needs of older adults.

BHRS Response: Included in the BHSA Integrated Plan are programs that address early identification and engagement of older adults showing signs of behavioral health concerns, strengthen peer support for older adults, and improve linkage to behavioral health services for older adults.

Stakeholder group that provided feedback
Family member of individual with lived experience

Summarize the substantive revisions recommended this stakeholder during the comment period
Support to address suicides and overdoses as local behavioral health goals

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

Substantive recommendations
One member of the Behavioral Health Board expressed support for housing and peer respite option in Marin and support to provide SUD treatment services with housing interventions.

One member of the Behavioral Health Board expressed concern over disproportionate amount of Early Intervention funding for youth. BHRS Response: At least 51% of the BHSS Early Intervention funding must be used to serve eligible individuals who are 25 years of age and younger, including transitional aged youth.

No substantive revisions made.

County Behavioral Health Services Care Continuum

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

County Behavioral Health Services Care Continuum

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

Mark section as complete

County Provider Monitoring and Oversight

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

Medi-Cal Quality Improvement Plans

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

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

Marin_FY 25-26 Integrated Quality Improvement Workplan.pdf

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

No

Contracted BHSA Provider Locations

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

Services Provided



Number of contracted BHSA provider locations

Services Provided	Number of contracted BHSA provider locations
Mental Health (MH) services only	19
Substance Use Disorder (SUD) services only	0
Both MH and SUD services	3

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

Services Provided	Number of Contracted BHSA Provider Locations
SMHS only	6
DMC/DMC-ODS only	0
Both SMHS and DMC/DMC-ODS systems	0

All BHSA Provider Locations

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

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

14

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

BHRS has been collaborating with Carelon and Partnership HealthPlan to support MCP contracting at provider locations. Additionally, in partnership with MCPs, BHRS will hold a MCP contracting summit with providers in October 2025.

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

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

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

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

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

No

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

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

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

Yes

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

Yes

Behavioral Health Services Act/Fund Programs

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

Behavioral Health Services and Supports (BHSS)

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

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General

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

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

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

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

Please select the service types provided under Program

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

Please describe the specific services provided
Casa René is a 10-bed Crisis Residential Unit (CRU) administered by Buckelew Programs. The program is expected to reduce unnecessary acute psychiatric hospitalizations by providing a home-like setting where individuals can resolve crises in the community and re-stabilize for up to thirty (30) days.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	188
FY 2027 – 2028	192
FY 2028 – 2029	196

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
Average of FY22/23 and FY23/24 individuals served with 2% yearly growth

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

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

Please select the service types provided under Program
Mental health services
Supportive services
Substance Use Disorder (SUD) treatment services

Please describe the specific services provided
Provide culturally responsive and recovery-oriented peer services. Improved support for family members. Enhancing services to underserved populations.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	2570
FY 2027 – 2028	2634
FY 2028 – 2029	2700

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
FY23/24 individuals served with 2-3% yearly growth

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

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

Please select the service types provided under Program
Supportive services
Mental health services

Please describe the specific services provided
Supportive and mental health services at Carmelita House, under Marin's MHSA "Housing to Healing: A Re-Entry Community For Women" Innovation project ending in January 2027. This includes somatic healing approaches, supportive services, and trauma therapy.

Supportive and mental health services at Permanent Supportive Housing sites.

Coordinated supportive services to clients who are homeless or at-risk of homelessness to assist in achieving housing stability by supporting clients in finding and maintaining housing and navigating housing voucher bureaucracy via Shelter+Care.

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

Plan Period by FY	**Projected Number of Individuals Served**
FY 2026 – 2027	395
FY 2027 – 2028	415
FY 2028 – 2029	435

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
FY22/23 and FY23/24 individuals served with 5% yearly growth based on anticipated increased number of individuals experiencing homelessness receiving services.

Early Intervention (EI) Programs

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

Program or service name
Early Childhood Behavioral Health

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

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

Please specify "other" type of Treatment Services and Supports

Infant and Early Childhood Mental Health Consultation

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

Yes

Please select the EBPs and CDEPs that apply

Infant and Early Childhood Mental Health Consultation
Triple P - Positive Parenting Program (Triple P)
Screening, Brief Intervention, Referral to Treatment (SBIRT)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Triple P, SBIRT, Infant and Early Childhood Mental Health Consultation

Please describe intended outcomes of the program or service

• Earlier identification of infants and young children exposed to, or who are at risk of exposure to, adverse childhood experiences (ACEs) and traumatic childhood events, environmental trauma including community violence, generational trauma, institutional trauma, and prolonged toxic stress
• Earlier identification and referral to services for children at risk of removal from home
• Increased capacity of caregivers to promote healthy social and emotional development in children
• Increased timely access to culturally responsive and linguistically appropriate behavioral health services for children ages zero to five and their caregivers

• Reduced likelihood of behavioral health difficulties and school failure in pre-school and beyond
• Reduced severity and duration of early symptoms of depression, anxiety, trauma, and social isolation
• Reduced disparities in access to care for children

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	200
FY 2027 – 2028	205
FY 2028 – 2029	210

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
The county has been partnering with community-based providers to provide early childhood mental health PEI programming targeting the mental health needs of eligible children and youth who are zero to five years of age for many years.

Early Intervention (EI) Programs

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

Program or service name
School-Age Behavioral Health

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

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

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

Yes

Please select the EBPs and CDEPs that apply

Dialectical Behavior Therapy
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
Eye Movement Desensitization and Reprocessing (EMDR)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
DBT, TF-CBT, EMDR

Please describe intended outcomes of the program or service

• Reduced likelihood of behavioral health problems and school failure
• Improved academic performance and readiness to learn
• Improved school connectedness
• Early identification of students with behavioral health difficulties and increased timely access to culturally responsive and linguistically appropriate behavioral health services
• Early identification and engagement of students from underserved cultural communities showing early signs of behavioral health concerns
• Reduced disparities in access to care for youth
• Increased access to brief, culturally and linguistically responsive behavioral health services
• Improved linkage to short-term therapeutic and recovery-oriented services
• Reduced severity and duration of early symptoms of depression, anxiety, trauma, and social isolation

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

No

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	250
FY 2027 – 2028	255
FY 2028 – 2029	260

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

The county has been partnering with community-based providers to provide behavioral health early intervention programming targeting eligible school aged youth who have significantly higher risk factors due to variables such as adverse childhood experiences, severe trauma, poverty, family conflict, domestic violence, racism, social inequality, or other related issues. Additionally, the county and community partners have focused on providing services for underserved youth and families, including Spanish speaking youth, newcomer students, LGBTQIA+ youth, youth in rural communities, as well as expanded efforts to provide accessible services within schools and community settings.

Early Intervention (EI) Programs

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

Program or service name

Transition Age Youth (TAY)

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

Outreach
Access and Linkage: Screenings
Access and Linkage: Referrals
Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

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

Yes

Please select the EBPs and CDEPs that apply

Cognitive Behavioral Therapy (CBT) for Anxiety
Cognitive Behavioral Therapy (CBT) for Depression
Screening, Brief Intervention, Referral to Treatment (SBIRT)
Motivational Enhancement Therapy (MET) / Motivational Interviewing

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
CBT, SBIRT

Please describe intended outcomes of the program or service

• Reduced likelihood of school failure, unemployment, and/or justice-involvement
• Reduced likelihood of intentional and nonintentional drug overdoses
• Increased access to services and supports that prevent, respond, and treat a behavioral health crisis
• Early identification of youth with behavioral health problems and increased timely access to culturally responsive and linguistically appropriate behavioral health services
• Increased access to brief, culturally and linguistically responsive mental health services
• Improved linkage to short-term therapeutic and recovery-oriented services
• Reduced severity and duration of early symptoms of depression, anxiety, trauma, and social isolation

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

No

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	720
FY 2027 – 2028	725
FY 2028 – 2029	730

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

Projections are based on past MHSA data for TAY and their families. A modest annual growth rate of 2% was applied to reflect service demand and continued outreach.

Early Intervention (EI) Programs

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

Program or service name

Our Communities

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

Outreach
Access and Linkage: Screenings
Access and Linkage: Assessments
Access and Linkage: Referrals
Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

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

Please select the EBPs and CDEPs that apply
Motivational Enhancement Therapy (MET) / Motivational Interviewing
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
Screening, Brief Intervention, Referral to Treatment (SBIRT)
Acceptance and Commitment Therapy (ACT)
Cognitive Behavioral Therapy (CBT) for Anxiety
Cognitive Behavioral Therapy (CBT) for Depression
Dialectical Behavior Therapy
Collaborative Care Model
Seeking Safety (SS)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
MI, TF-CBT, SBIRT, ACT, Collaborative Care, CBT, DBT, Seeking Safety

Please describe intended outcomes of the program or service
• Early identification and engagement of individuals from underserved cultural and geographic communities showing early signs of behavioral health concerns.
• Increased access to culturally and linguistically responsive early intervention therapeutic and recovery-oriented services.
• Strengthened peer-led support to improve engagement and trust among high-barrier populations.
• Enhanced potential responder capacity to recognize and respond to early signs of mental health, suicidal and substance use issues
• Reduced severity and duration of early symptoms of depression, anxiety, trauma, and social isolation
• Decreased need for emergency or acute behavioral health interventions

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	675
FY 2027 – 2028	685
FY 2028 – 2029	700

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

Projections are based on three-year averages of participation across previous MHSA programs Enterprise Resource Center peer drop-in services, Latino Community Connection, and Community Training and Supports.

Early Intervention (EI) Programs

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

Program or service name

Compassion to Action

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

Outreach
Access and Linkage: Screenings
Access and Linkage: Referrals
Access and Linkage: Assessments
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide

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

Please select the EBPs and CDEPs that apply
Dialectical Behavior Therapy

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
DBT, Didi Hirsch Survivors of Suicide Attempts (SOSA)

Please describe intended outcomes of the program or service
• Early identification and engagement of individuals experiencing initial signs of suicidality or related behavioral health concerns.
• Timely access to short-duration, culturally responsive behavioral health services.
• Increased linkage to appropriate clinical and non-clinical supports.
• Reduction in the severity and frequency of suicidal ideation and behaviors.
• Decreased need for emergency or inpatient behavioral health services.
• Improved individual functioning, safety, and stabilization.
• Strengthened peer support through trained peer specialists who offer engagement, navigation, and emotional support
• Enhanced continuity of care and follow-up after suicidal behavior or crisis.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

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

Plan Period by FY	Projected Number of Individuals Served

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	6700
FY 2027 – 2028	200
FY 2028 – 2029	215

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

Projections are based on individuals reached through Suicide response programming (988, LOSS Team) and individuals served through the Crisis Aftercare Team in FY23/24. Reduced estimates in FY27/28 and FY28/29 reflect shifting 988 to State funding.

Early Intervention (EI) Programs

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

Program or service name

Caring Connections

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

Outreach
Access and Linkage: Screenings
Access and Linkage: Assessments
Access and Linkage: Referrals
Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

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

Please select the EBPs and CDEPs that apply
Acceptance and Commitment Therapy (ACT)
Motivational Enhancement Therapy (MET) / Motivational Interviewing
Screening, Brief Intervention, Referral to Treatment (SBIRT)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Acceptance and Commitment Therapy, Screening, Brief Intervention, and Referral to Treatment, Motivational Interviewing

Please describe intended outcomes of the program or service
• Early identification and engagement of older adults showing initial signs of behavioral health concerns
• Strengthened peer support through trained older adult peer specialists who offer engagement, navigation, and emotional support
• Improved linkage to clinical, community-based, and social support services tailored to the needs of older adults
• Increased potential responders capacity to recognize behavioral health symptoms in older adults
• Reduction in severity and duration of depressive symptoms, anxiety, trauma-related stress, or social isolation
• Decreased risk of behavioral health crises and reduced use of emergency or inpatient services
• Improved overall well-being, daily functioning, and quality of life for participating older adults

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	200
FY 2027 – 2028	205
FY 2028 – 2029	210

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

Projections are based on the three-year average reported in MHSA annual updates, with modest growth of 2% applied annually to reflect the upward trend observed in FY 24/25 and anticipated ongoing outreach.

Early Intervention (EI) Programs

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

Program or service name

Veterans

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

Outreach
Access and Linkage: Screenings
Access and Linkage: Referrals
Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

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

Please select the EBPs and CDEPs that apply
Motivational Enhancement Therapy (MET) / Motivational Interviewing

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
MI

Please describe intended outcomes of the program or service
• Early identification and engagement of veterans showing initial signs of behavioral health concerns.
• Improved linkage to clinical, community-based, and social support services tailored to the needs of veterans.
• Increased potential responders capacity to recognize behavioral health symptoms in veterans.
• Decreased risk of behavioral health crises and reduced use of emergency or inpatient services
• Improved overall well-being, daily functioning, and quality of life for participating veterans

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	120

Plan Period by FY	Projected Number of Individuals Served
FY 2027 – 2028	123
FY 2028 – 2029	126

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

Projections are based on the three-year average reported in MHSA annual updates, with modest growth of 2% applied annually to reflect recent upward trends and expanded outreach.

Coordinated Specialty Care for First Episode Psychosis (CSC) program

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

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

CSC program name

Marin's Early Psychosis Program

CSC program description

Marin's Early Psychosis Program (EPP) will deliver comprehensive, coordinated treatment experiencing early signs and symptoms of a psychotic disorder, as well as providing families the tools to support their loved ones in their recovery process. The program will provide outreach and education to a variety of Marin County agencies, including schools and school districts, community-based agencies, Marin County programs and services and other interested parties. The program will engage unserved individuals in the community who may be experiencing symptoms of early psychosis to help them access services. The program will provide screening and assessment for clients to determine eligibility for coordinated specialty care services, short-term services to support clients during transition to other providers, and information/resources for clients not eligible for their direct services, as well as 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

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

CSC Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	24
Number of Uninsured Individuals	<11*

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

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

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

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

Please list the other funding source(s)
Federal Mental Health Block Grant, Medi-Cal reimbursement

Outreach and Engagement (O&E) Program

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

Program or activity name
Community Outreach and Engagement

Please describe the program or activity
Outreach and engagement to underserved individuals to successfully connect them to behavioral health services. This program will support regional equity and address disparities through culturally responsive and linguistically appropriate services, closed-loop referrals, field-based screenings and assessments.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	1200
FY 2027 – 2028	1260
FY 2028 – 2029	1323

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

FY23/24 individuals served and expanded regional equity with 5% yearly growth

County Workforce, Education, and Training (WET) Program

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

Program or activity name

Continuing Education

Please select which of the following categories the activity falls under

Continuing Education

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

BHRS identified workforce disparities related to the availability of staff who can provide culturally and linguistically responsive services, particularly for Marin County's Spanish-speaking communities. In response, BHRS is implementing strategies to strengthen workforce capacity and improve equitable access to care. BHRS is prioritizing the preservation of existing positions and avoiding layoffs to maintain service continuity and retain experienced staff. BHRS is hiring bilingual Spanish and Vietnamese speakers whenever possible, with many positions offering a salary differential for bilingual skills. Looking forward, BHRS will focus on leveraging state workforce development initiatives, strengthening local training and internship pipelines, and implementing retention strategies to build a financially sustainable, highly skilled, and representative workforce. Additionally, BHRS recently awarded several competitive Requests for Proposals that expand access to culturally and linguistically responsive early intervention behavioral health services throughout Marin County.

Workforce, Education, and Training programs are central to building and sustaining a diverse behavioral health workforce that is culturally responsive, trauma-informed, and committed to client- and family-driven services. Funding for continuing education provides training for staff and contracted providers and supports clinicians in completing the coursework required to maintain professional licenses and certifications. Training and technical assistance funds also support clinical supervision for unlicensed staff, enabling them to accrue the supervised hours necessary for licensure and career advancement.

Career pathway investments support master's-level interns pursuing careers in community behavioral health, helping to strengthen the future workforce pipeline. In addition, funding for peer certification fees prepares individuals with lived experience to work within the public behavioral health system, increasing representation and strengthening peer-informed services.

Collectively, these initiatives promote equitable access to career opportunities, increase workforce diversity, and enhance the capacity of Marin County’s behavioral health system to provide culturally and linguistically responsive services that meet the needs of the community.

County Workforce, Education, and Training (WET) Program

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible.

Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).
For each program or activity that is part of the county's overall WET program, provide the following information. If the county provides more than one program or activity type, use the "Add" button.
For related policy information, refer to 7.A.4 Workforce Education and Training .

Program or activity name
Training and Technical Assistance

Please select which of the following categories the activity falls under
Workforce Recruitment, Development, Training, and Retention

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
BHRS identified workforce disparities related to the availability of staff who can provide culturally and linguistically responsive services, particularly for Marin County's Spanish-speaking communities. In response, BHRS is implementing strategies to strengthen workforce capacity and improve equitable access to care. BHRS is prioritizing the preservation of existing positions and avoiding layoffs to maintain service continuity and retain experienced staff. BHRS is hiring bilingual Spanish and Vietnamese speakers whenever possible, with many positions offering a salary differential for bilingual skills. Looking forward, BHRS will focus on leveraging state workforce development initiatives, strengthening local training and internship pipelines, and implementing retention strategies to build a financially sustainable, highly skilled, and representative workforce. Additionally, BHRS recently awarded several competitive Requests for Proposals that expand access to culturally and linguistically responsive early intervention behavioral health services throughout Marin County.

Workforce, Education, and Training programs are central to building and sustaining a diverse behavioral health workforce that is culturally responsive, trauma-informed, and committed to client- and family-driven services. Funding for continuing education provides training for staff and contracted providers and supports clinicians in completing the coursework required to maintain professional licenses and certifications. Training and technical assistance funds also support clinical supervision for unlicensed staff, enabling them to accrue the supervised hours necessary for licensure and career advancement.

Career pathway investments support master's-level interns pursuing careers in community behavioral health, helping to strengthen the future workforce pipeline. In addition, funding for peer certification fees prepares individuals with lived experience to work within the public behavioral health system, increasing

representation and strengthening peer-informed services.

Collectively, these initiatives promote equitable access to career opportunities, increase workforce diversity, and enhance the capacity of Marin County's behavioral health system to provide culturally and linguistically responsive services that meet the needs of the community.

County Workforce, Education, and Training (WET) Program

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

Program or activity name
Behavioral Health Career Pathway Programs Internship

Please select which of the following categories the activity falls under
Workforce Recruitment, Development, Training, and Retention

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
BHRS identified workforce disparities related to the availability of staff who can provide culturally and linguistically responsive services, particularly for Marin County's Spanish-speaking communities. In response, BHRS is implementing strategies to strengthen workforce capacity and improve equitable access to care. BHRS is prioritizing the preservation of existing positions and avoiding layoffs to maintain service continuity and retain experienced staff. BHRS is hiring bilingual Spanish and Vietnamese speakers whenever possible, with many positions offering a salary differential for bilingual skills. Looking forward, BHRS will focus on leveraging state workforce development initiatives, strengthening local training and internship pipelines, and implementing retention strategies to build a financially sustainable, highly skilled,

and representative workforce. Additionally, BHRS recently awarded several competitive Requests for Proposals that expand access to culturally and linguistically responsive early intervention behavioral health services throughout Marin County.

Workforce, Education, and Training programs are central to building and sustaining a diverse behavioral health workforce that is culturally responsive, trauma-informed, and committed to client- and family-driven services. Funding for continuing education provides training for staff and contracted providers and supports clinicians in completing the coursework required to maintain professional licenses and certifications. Training and technical assistance funds also support clinical supervision for unlicensed staff, enabling them to accrue the supervised hours necessary for licensure and career advancement.

Career pathway investments support master's-level interns pursuing careers in community behavioral health, helping to strengthen the future workforce pipeline. In addition, funding for peer certification fees prepares individuals with lived experience to work within the public behavioral health system, increasing representation and strengthening peer-informed services.

Collectively, these initiatives promote equitable access to career opportunities, increase workforce diversity, and enhance the capacity of Marin County's behavioral health system to provide culturally and linguistically responsive services that meet the needs of the community.

County Workforce, Education, and Training (WET) Program

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

Program or activity name
Professional Licensure and/or Certification

Please select which of the following categories the activity falls under
Professional Licensing and/or Certification Testing and Fees

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
BHRS identified workforce disparities related to the availability of staff who can provide culturally and linguistically responsive services, particularly for Marin County's Spanish-speaking communities. In response, BHRS is implementing strategies to strengthen workforce capacity and improve equitable access to care. BHRS is prioritizing the preservation of existing positions and avoiding layoffs to maintain service continuity and retain experienced staff. BHRS is hiring bilingual Spanish and Vietnamese speakers whenever possible, with many positions offering a salary differential for bilingual skills. Looking forward, BHRS will focus on leveraging state workforce development initiatives, strengthening local training and internship pipelines, and implementing retention strategies to build a financially sustainable, highly skilled, and representative workforce. Additionally, BHRS recently awarded several competitive Requests for Proposals that expand access to culturally and linguistically responsive early intervention behavioral health services throughout Marin County.

Workforce, Education, and Training programs are central to building and sustaining a diverse behavioral health workforce that is culturally responsive, trauma-informed, and committed to client- and family-driven services. Funding for continuing education provides training for staff and contracted providers and supports clinicians in completing the coursework required to maintain professional licenses and certifications. Training and technical assistance funds also support clinical supervision for unlicensed staff, enabling them to accrue the supervised hours necessary for licensure and career advancement.

Career pathway investments support master's-level interns pursuing careers in community behavioral health, helping to strengthen the future workforce pipeline. In addition, funding for peer certification fees prepares individuals with lived experience to work within the public behavioral health system, increasing representation and strengthening peer-informed services.

Collectively, these initiatives promote equitable access to career opportunities, increase workforce diversity, and enhance the capacity of Marin County’s behavioral health system to provide culturally and linguistically responsive services that meet the needs of the community.

Capital Facilities and Technological Needs (CFTN) Program

For each project that is part of the county’s CFTN project, provide the following information. If the county provides more than one project, use the “Add” button. Additional information on CFTN policies

can be found in Policy Manual Chapter 7, Section A.5 .

Project name
Electronic Health Record And Practice Management System Enhancements

Please select the type of project
Technological needs project

If Technological Needs Project, please select the focus area(s) of the project
Electronic health record system

Please describe the project
Improve performance of the electronic health record (EHR) system to support optimal clinical effectiveness and provide accessible and meaningful consumer outcome data with a focus on improvements for reporting for state requirements and local evaluation efforts; enhancing care coordination efforts through enhanced client care teams; and using technology to improve our overall system of care.

Capital Facilities and Technological Needs (CFTN) Program

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

Project name
Telehealth Improvements

Please select the type of project
Technological needs project

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

Please describe the project

Strengthen telehealth options, including the ability to provide group services via telehealth. Investments in software and hardware for client use to allow them to access telehealth services in locations throughout the county (including kiosks or personal devices as needed). The telehealth platform allows clients to log into virtual appointments remotely and the lobby administrator places clients into virtual meeting rooms to meet with their treatment provider. These services are provided between 8:00 a.m. and 8:00 p.m. Monday through Friday, (with an option of Saturdays as needed), excluding County holidays.

Full Service Partnership Program

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

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Please review the total estimated number of individuals who may be eligible for each of the following Full Service Partnership (FSP) services (consistent with the Service Criteria in the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Evidence-Based Practice (EBP) Policy Guide , the Policy Manual Chapter 7, Section B , and forthcoming High Fidelity Wraparound (HFW) Medi-Cal Guidance): Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT), Full Service Partnership (FSP) Intensive Case Management (ICM), HFW and Individual Placement and Support (IPS) Model of Supported Employment). Please input the estimates provided to the county in the table below

Total Adult FSP Eligible Population	**Estimates**

Total Adult FSP Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	326
Number of Uninsured Individuals	40
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	116

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

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

ACT Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	44
Number of Uninsured Individuals	<11*

FACT Eligible Population (ACT with Justice-System Involvement)	Estimates
Number of Medi-Cal Enrolled Individuals	22

FACT Eligible Population (ACT with Justice-System Involvement)	Estimates
Number of Uninsured Individuals	3

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

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

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	14	14	14
Total Number of Teams	1	1	1

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

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

FSP ICM Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	260
Number of Uninsured Individuals	32

FSP ICM Practitioners and Teams Needed	**Estimates**
Number of Practitioners Needed to Serve Total Eligible Population	15
Number of Teams Needed to Serve Total Eligible Population	3

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

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

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

High Fidelity Wraparound (HFW) Eligible Population

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

HFW Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	84
Number of Uninsured Individuals	18

HFW Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	31
Number of Teams Needed to Serve Total Eligible Population	1

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

County Actuals	**FY 26-27**	**FY 27-28**	**FY 28-29**
Total Number of Practitioners	11	13	15
Total Number of Teams	1	1	1

Individual Placement and Support (IPS) Eligible Population

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

IPS Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	596
Number of Uninsured Individuals	73

IPS Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	43
Number of Teams Needed to Serve Total Eligible Population	17

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

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	7	9	9
Total Number of Teams	3	4	4

Full Service Partnership (FSP) Program Overview

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

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

Yes

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

It is anticipated that some practitioners in the adult system of care will be trained in both ACT and FACT in order to ensure sufficient capacity and flexibility to meet any changes in needs and demands. For the children's system of care, High Fidelity Wrap will be utilized.

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

Marin BHRS acknowledges that individuals are experts on their own life and that recovery involves working in partnership with individuals and their families or other natural supports. Strategies the county employs to support whole-person and trauma-informed approaches in partnership with families and other natural supports include:

· All of Marin County's Youth and Family Services behavioral health programs, including Wraparound services, are family focused and utilize Child and Family Team (CFTs) to elicit and support family voice and choice in the services they receive. Our clinical teams receive extensive training on the impact of individual and transgenerational trauma on behavior.

· FSPs engage families and/or other natural support networks in the client's treatment and recovery support processes. BHRS also provides support, education, and skill-building for family members including through family groups and embedding Family Partners in FSP programs.

· FSP programs are staffed with Peers, as well as utilize Recovery Coaches, who also engage and provide support to the client and their families and assist with referrals, linkages and other recovery supports.

· BHRS supports various workforce development initiatives, such as offering training on providing trauma-informed care, peer led services and modalities, and other pertinent topics that support capacity to effectively support whole-person approaches in partnership with families and other natural supports.

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

The county implements numerous strategies to provide culturally and linguistically responsive services in order to reduce disparities among FSP participants. Examples include implementing initiatives to increase bilingual staffing and services delivered in Spanish and Vietnamese, strengthening peer and family supports, and supporting workforce development efforts related to developing career pathways, providing culturally responsive services and supervision, and competency development. In addition to providing field-based services, the county's behavioral health clinics and services are located throughout the County to support geographically equitable access to care.

In addition to operating under a robust Cultural Humility and Responsivity Plan, BHRS also leads and participates in numerous initiatives focused on reducing disparities, such as the Equity and Community Partnerships Committee, Language Access Workgroup, Latine Steering Committee, LGBTQ+ Collaborative, and Addressing Harm Workgroup, among others.

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

Homelessness
Institutionalization
Justice involvement
Removal of children from home
Untreated behavioral health conditions

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

Marin BHRS is providing ongoing engagement services to individuals receiving FSP ICM services using the following strategies:
a. Maintaining low staff to client ratios to support individualized care, frequent contact and ongoing engagement
b. Supporting a multi-disciplinary team-based approach, including practitioners with lived experience, to provide coordinated and integrated care
c. Maintaining regular communication and follow-up, including providing a minimum of one service per week, as clinically indicated
d. Supporting low barrier access to care through providing services in environments where they need services and offering a flexible service delivery approach
e. Promoting connection to community-based and recovery-oriented resources, such as the Enterprise Resource Center and Empowerment Clubhouse

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

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.)

Marin County BHRS will comply with the required FSP levels of care by implementing the following:
· Transition two (2) existing FSP teams to operate as one (1) full ACT team. Reconfiguring staffing, as needed, to support capacity development to effectively serve individuals with co-occurring SMI and substance use conditions. The team will participate in training provided by the Centers of Excellence, as well as in fidelity assessment activities.
· Transition three (3) existing FSP teams to operate as three (3) FSP ICM teams, including reconfiguring staffing, as needed, to support capacity development to effectively serve individuals with co-occurring SMI

and substance use conditions.
· Update practices for identifying and facilitating clinically appropriate transitions between BHRS programs to the indicated FSP level of care, as applicable.

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

Primary substance use disorder (SUD) FSPs
No

Outreach activities related to enrolling individuals living with significant behavioral health needs in an FSP (activities that fall under assertive field-based initiation of substance use disorder treatment services will be captured separately in the next section)
No

Other recovery-oriented services
No

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

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

In, or at-risk of being in, the juvenile justice system
BHRS leadership continue to participate in the county's Executive Committee Juvenile Justice Workgroup, to best identify and respond to the community's changing Juvenile Justice needs.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
Marin Youth and Family Services is a partner of the Marin LGBTQ+ Center as well as other local LGBTQ+ advocacy groups. Through these relationships our leadership team can hear about changes in the experience and needs of LGBTQ+ youth in Marin County. Additionally, a LGBTQ+ focused session was held during community planning.

In the child welfare system
Marin BHRS is a strong partner with our Child Welfare Division (Children and Family Services), who not only track data on affected children and youth, but also lead a quarterly multidisciplinary meeting (AB 2083) that reviews trends and needs in the Child Welfare population.

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

Older adults
The Helping Older People Excel (HOPE) Program has been a successful MHSA-funded county-operated Full-Service Partnership (FSP) serving older adults with serious mental illness who are at risk of homelessness, hospitalization, or institutionalization since 2007. This program will continue as a BHSA-funded program. Additionally, BHRS regularly engages with stakeholders who represent the unique needs of older adults.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
BHRS regularly partners with the Marin LGBTQ+ Center as well as other local LGBTQ+ advocacy groups. Additionally, a LGBTQ+ focused session was held during community planning.

In, or are at risk of being in, the justice system
The Marin County Support and Treatment After Release Program has been an MHSA-funded county-operated Full-Service Partnership serving adults with serious mental illness who are at risk of incarceration or re-incarceration since 2006. In addition to reviewing the data and engaging with stakeholders, BHRS receives ongoing input on behavioral health priorities from community-based agencies and advocates who serve individuals with justice system experience, public safety partners, and members of the judicial system.

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

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.

Existing Programs for Assertive Field-Based SUD Treatment Services

Targeted outreach

Existing programs

Suspected Non-Fatal Overdose Follow-Up; Ritter Center's Health and Wellness Outreach Team

Program descriptions

DMC-ODS Providers perform outreach to individuals that experienced a suspected non-fatal overdose. Individuals are identified through EMS records and/or ED data from Point Click Care.

The Outreach teams include a behavioral health van and Street Medicine team, staffed with a medical provider, patient navigator/ medical assistant, benefits specialist, and harm reduction outreach workers. The Teams provide both urgent primary medical care and preventive care, while connecting patients to wrap-around services that may include behavioral health support, shelter and housing resources, medical insurance registration, and access to food and income.

Current funding source

Suspected Non-Fatal Overdose Follow-Up: Opioid Settlement Fund; General Fund; SUBG

Ritter Center's Health and Wellness Outreach Team: Grant funding from HHS – Public Health and Anthem Blue Cross; Medi-Cal

BHSA changes to existing programs to meet BHSA requirements

Explore SMHS Providers also conducting outreach and consider alternate outreach strategies to support higher SUD engagement among individuals with a suspected non-fatal overdose. Explore outreach and engagement strategies to youth and TAY population.

Explore the feasibility of expanding outreach locations and direct MAT prescribing.

Expected timeline of operation
Suspected Non-Fatal Overdose Follow-Up: Limited outreach currently in operation

Ritter Center's Health and Wellness Outreach Team: Currently in operation

Mobile-field based programs

Existing programs
Ritter Center's Health and Wellness Outreach Team

Program descriptions
The Outreach teams include a behavioral health van and Street Medicine team, staffed with a medical provider, patient navigator/ medical assistant, benefits specialist, and harm reduction outreach workers. The Teams provide both urgent primary medical care and preventive care, while connecting patients to wrap-around services that may include behavioral health support, shelter and housing resources, medical insurance registration, and access to food and income.

Current funding source
Grant funding from HHS – Public Health and Anthem Blue Cross; Medi-Cal

BHSA changes to existing programs to meet BHSA requirements
Explore the feasibility of expanding outreach locations and direct MAT prescribing.

Expected timeline of operation
Limited outreach currently in operation

Open-access clinics

Existing programs
Marin Health Emergency Department; Ritter Center; Marin Treatment Center

Program descriptions
Marin Health Emergency Department, which is a CA Bridge Site, performs 24/7 MAT Inductions and referrals to outpatient clinics for ongoing MAT.

Ritter Center is a Federally Qualified Health Center (FQHC) offering low barrier access to MAT/SUD treatment.

Marin Treatment Center is the County's Opioid Treatment Program and offers MAT, including methadone.

Current funding source
Marin Health Emergency Department: Medi-Cal, Medicare, Commercial Insurance

Ritter Center: Medi-Cal; Other

Marin Treatment Center: DMC-ODS, BHSOAC Grant, Medicare, Commercial Insurance

BHSA changes to existing programs to meet BHSA requirements
Marin Health Emergency Department: N/A

Ritter Center: Exploring the feasibility of adding prescribers or offering drop-in hours to support rapid MAT access.

Marin Treatment Center: Expanding prescriber capacity to support rapid access to MAT.

Expected timeline of operation
All programs are currently in operation

New Programs for Assertive Field-Based SUD Treatment Services

Targeted outreach

New programs
CalAIM/Jail Behavioral Health Services; DMC-ODS Outpatient and Residential settings; Mobile Outreach (Provider TBD)

Program descriptions
CalAIM/Jail Behavioral Health Services: In-custody screening and assessment for MAT and timely linkage to in-custody and community-based MAT.

DMC-ODS Outpatient and Residential settings: DMC-ODS Outpatient and Residential provider sites to implement new or expand existing MAT Prescriber capacity.

Mobile Outreach (Provider TBD): Expand mobile outreach efforts to include additional locations, as applicable, and workflows/capacity to provide rapid access to SUD services, including MAT.

Planned funding
CalAIM/Jail Behavioral Health Services: Medi-Cal; County General Fund

DMC-ODS Outpatient and Residential settings: Drug/Medi-Cal; BHSOAC Grant

Mobile Outreach (Provider TBD): Medi-Cal; BHSA; TBD

Planned operations
CalAIM/Jail Behavioral Health Services: In partnership with the Sheriff, Probation and Detention Health, implement new workflows to identify and link individuals to MAT, as clinically indicated.

DMC-ODS Outpatient and Residential settings: Embed MAT Prescribers in at least four (4) DMC-ODS Outpatient and Residential provider sites and implement new workflows to identify and serve clients appropriate for MAT.

Mobile Outreach (Provider TBD): Issue an RFP, if applicable, to solicit a Provider to implement/ expand mobile outreach efforts that facilitate rapid access to SUD services.

Expected timeline of implementation
CalAIM/Jail Behavioral Health Services: October 2026

DMC-ODS Outpatient and Residential settings: July 2026

Mobile Outreach (Provider TBD): December 2026

Mobile-field based programs

New programs
Mobile Outreach (Provider TBD)

Program descriptions
Expand mobile outreach efforts to include additional locations, as applicable, and workflows/capacity to provide rapid access to MAT.

Planned funding
Medi-Cal; BHSA; TBD

Planned operations
Issue an RFP, if applicable, to solicit a Provider to implement/ expand mobile outreach efforts that facilitate rapid access to SUD services.

Expected timeline of implementation
December 2026

Open-access clinics

New programs
Ritter Center; Marin Treatment Center; Telehealth (Provider TBD)

Program descriptions
Ritter Center: Ritter Center is a Federally Qualified Health Center (FQHC) offering low barrier access to MAT/SUD Treatment.

Marin Treatment Center: Marin Treatment Center is the County's Opioid Treatment Program and offers MAT, including methadone.

Telehealth (Provider TBD): Contract with a telehealth provider(s) to offer rapid access to MAT.

Planned funding
Ritter Center: Medi-Cal; Other

Marin Treatment Center: Multiple: DMC-ODS, BHSOAC Grant, Medicare, Commercial Insurance

Telehealth (Provider TBD): Medi-Cal; Commercial Insurance

Planned operations
Ritter Center and Marin Treatment Center: Promote availability of Ritter Center's and Marin Treatment Center's MAT services, including ensuring targeted outreach providers, FSP staff and Mobile Field-Based Program have workflows to refer to these services, as appropriate.

Telehealth (Provider TBD): Issue an RFP; develop a referral arrangement and/or expand existing contracts to provide MAT via telehealth.

Expected timeline of implementation
December 2026 all programs

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

Describe how the county will assess the gap between current county MAT resources (including programs and providers) and MAT resources that can meet estimated needs
Marin County will assess the gaps between current county MAT resources and MAT resources that can meet estimated needs by analyzing data including, but not limited to:
· Prevalence rates of alcohol use disorders (AUD) and opioid use disorders (OUD) among the prospective service population
· Percentage of BHRS clients with an AUD and/or OUD who are prescribed MAT
· Timeliness data for accessing MAT services
· Inventory of number, type and capacity of organizations serving the prospective service population that offer MAT (e.g. location of MAT clinics, FTE/availability of MAT prescribers, MAT medications available, wait times for MAT, etc.)
· Mapping MAT availability and metrics such as overdoses and location of the service population
· MAT initiation and retention data, including analysis by race/ethnicity, primary language and other characteristics to understand any disparities in access, engagement and outcomes
· Solicit and analyze trends in qualitative data from hospital Substance Use Navigators on clients who are interested in MAT but for whom intake hours or appointment availability is a barrier
· Identifying the need for MAT initiation and maintenance in the jail and any gaps and strategies to address continuity of care upon release
· Other potential barriers to MAT, such as pharmacy access, stigma or other issues identified by individuals with an AUD or OUD and other stakeholders.

Select the following practices the county will implement to ensure same day access to MAT
Contract directly with MAT providers in the County
Leverage telehealth model(s)

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

Housing Interventions

Planning

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

System Gaps

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

Supportive housing
Medium gap

Apartments, including master-lease apartments
Medium gap

Single and multi-family homes
Medium gap

Housing in mobile home communities
Large gap

(Permanent) Single room occupancy units
Large gap

(Interim) Single room occupancy units
Large gap

Accessory dwelling units, including junior accessory dwelling units
Medium gap

(Permanent) Tiny homes
Large gap

Shared housing
Medium gap

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

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

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

License-exempt room and board
Medium gap

Hotel and Motel stays
Medium gap

Non-congregate interim housing models
Large gap

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

Recuperative Care
Large gap

Short-Term Post-Hospitalization housing
Large gap

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

Peer Respite
Large gap

Permanent rental subsidies
Medium gap

Housing supportive services
Medium gap

What additional non-BHSA resources (e.g., county partnerships, vouchers, data sharing agreements) or funding sources will the county behavioral health system utilize (local, state, and federal) to expand supply and/or increase access to housing for BHSA eligible individuals **?**
Marin will leverage vouchers, State, and Federal funding to expand supply. Additionally, Marin will utilize MCPs transitional rent to increase access to housing. CalAIM Enhanced Care Management and Community Supports will be utilized to increase both access to housing and the number of individuals who stay permanently housed. In addition, Marin is utilizing Behavioral Health Bridge Housing (BHBH) Program to expand the supply of transitional housing, rental subsidies, and SLE subsidies. Of note, the Marin Housing Authority has been in a voucher shortfall since August 2024. This has slowed the availability for Section 8 Housing Choice Vouchers for unhoused individuals. Additionally, the Housing Authority has transitioned individuals and families who previously utilized an Emergency Housing Voucher onto the Housing Choice Voucher waitlist. These clients are prioritized higher than unhoused individuals, so they can retain housing. This has further reduced the availability of vouchers.

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?
Filling in gaps that will be left by both the end of the 6 month transitional rent subsidies by the managed care plans and by the end of BHBH in 2027, BHSA will be used to continue many of those successful programs. In addition, during this period of insufficient HUD vouchers, BHSA will be used to create 16 to 22 local Behavioral Health vouchers. In addition to rental assistance, BHSA Housing Interventions will also be used to create a peer respite facility and capital funding to complete a Homekey+ project converting a former convent into Permanent Supportive Housing.

What is the county behavioral health system's overall strategy to promote permanent housing placement and retention for individuals receiving BHSA Housing Interventions?
Marin views housing as a core component of treatment and recovery for people with serious mental illness and/or substance use disorders. The strategy centers on the idea that stable housing is the foundation which enables behavioral health treatment to be effective, and vice versa. The overall goal is to link people quickly to Coordinated Entry, behavioral health services, and housing. Marin expects that outreach staff will engage unsheltered individuals, especially in encampments, and provide warm hand-offs into BHSA-funded services, including initial behavioral health assessments and housing navigation. Specialized services including housing-focused case management and behavioral health treatment will be used to aid in housing retention.

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)?
BHRS provides behavioral health treatment, including case management, to increase the likelihood that individuals stay in PSH. BHRS coordinates with the Marin Housing Authority through the Coordinated Entry process to ensure that BHSA-eligible clients can access tenant-based vouchers. BHRS and community providers deliver services needed for clients with SMI/SUD to utilize these subsidies successfully. Under this BHSA plan, the housing component will fund rental and operating subsidies at four different PSH programs and will invest in capital development funding for a new PSH in year one. Of note, the Marin Housing Authority has been in a voucher shortfall since August 2024. This has slowed the availability for Section 8 Housing Choice Vouchers for unhoused individuals. Additionally, the Housing Authority has transitioned individuals and families who previously utilized an Emergency Housing Voucher onto the Housing Choice Voucher waitlist. These clients are prioritized higher than unhoused individuals, so they can retain housing. This has further reduced the availability of vouchers.

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

BHRS will ensure that behavioral health services are easily accessible across all housing settings. BHRS will contract with providers to deliver on-site case management, peer support, and recovery groups, ensuring continuity of care. BHRS will ensure that individuals placed in BHSA housing settings are connected to behavioral health services, including but not limited to FSPs, outpatient mental health services, and substance use disorder services. BHRS will partner with MCPs to ensure individuals receive ECM and Community Supports.

Eligible Populations

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

Marin will continue to partner with community agencies and Marin's CoC to proactively identify individuals experiencing homelessness who may be eligible for BHSA Housing Interventions. Additionally, Marin will expand outreach and engagement to individuals experiencing homelessness through BHSA Housing Interventions. Marin will also continue to link existing BHRS clients to BHSA Housing Interventions through screening for housing needs at initial assessment and throughout treatment within clinical programs. BHRS will provide direct referrals to Marin's Coordinated Entry system and support clients through the process of securing housing.

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

Yes

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

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

BHRS leadership continues to participate in the county's Executive Committee Juvenile Justice Workgroup, to address the unique needs of youth in, or at risk of, the juvenile justice system. In addition, Marin reviewed relevant data and incorporated community input to identify housing needs.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
Marin Youth and Family Services partners with the Marin LGBTQ+ Center and other local advocacy groups to elevate the voices of LGBTQ+ youth. Through these relationships our leadership team can hear about changes in the experience and needs of LGBTQ+ youth in Marin County. Additionally, a LGBTQ+ focused session was held during community planning where housing and LGBTQ+ affirming services were identified as priorities.

In the child welfare system
Marin BHRS is a strong partner with our Child Welfare Division (Children and Family Services), who not only track data on affected children and youth, but also lead a quarterly multidisciplinary meeting (AB 2083) that reviews trends and needs in the Child Welfare population.

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

Older adults
BHRS has developed an understanding of the housing needs of older adult through the Helping Older People Excel (HOPE) Program which has been a successful MHSA-funded county-operated Full-Service Partnership (FSP) serving older adults with serious mental illness who are at risk of homelessness, hospitalization, or institutionalization since 2007. In addition to reviewing relevant data, BHRS engaged with stakeholders who represent the unique needs of older adults, including the Marin County Aging and Adult Services and the Commission on Aging. Marin also held two older adult-focused community planning sessions to inform Marin's Housing Interventions services for older adults. Marin's first priority population identified for specialty housing program under MHSA was older adults resulting in the development of two MHSA housing programs for older adults with serious mental illness: Fireside and Victory Village. The Marin CoC Homelessness Policy Steering Committee also maintains a subcommittee on Older Adult Homelessness which meets regularly to discuss strategies and progress and shares that information with BHRS.

In, or are at risk of being in, the justice system
Since 2006, Marin BHRS has operated the Support and Treatment After Release (STAR) Full-Service Partnership, which provides intensive services to justice-involved adults with serious mental illness who are at risk of homelessness, incarceration, hospitalization, or institutionalization. In addition to analyzing relevant local data, BHRS receives ongoing input on behavioral health priorities from community-based agencies and advocates and public safety partners. Marin's Innovation project "From Housing to Healing: A Re-Entry Community for Women" has provided healing-centered and holistic treatment for women with a serious mental illness and potentially co-occurring substance use disorders who have been incarcerated or otherwise resided in a locked facility since 2022. Originally starting with 6 residents, Carmelita House was

expanded in 2023 to serve 8+ residents. The Transitional Housing portion of this Innovation project is funded using MHSA Innovation funding through January 2027 with the eligible housing costs falling under the Housing Bucket and the services under BHSS-Other. The increased understanding of the unique needs of women with lived experience in the justice system informed the decision to add a PSH component to Carmelita House.

In underserved communities

Marin County receives regular feedback on housing needs through ongoing partnerships with community agencies that serve BIPOC residents, immigrants, rural West Marin residents, and low-income communities disproportionately impacted by homelessness. Findings from the 2025 Community Health Assessment, which identified housing and homelessness as priority concerns, further informed planning. In addition, BHRS reviewed statewide behavioral health data on homelessness to identify disparities that Housing Interventions services can address in underserved communities. Additional analyses conducted by the Division of Homelessness and Coordinated Care has also identified a disproportionate number of BIPOC residents experiencing homelessness and the Division has crafted a series of race equity focused goals and strategies to reduce this disproportionate impact in homelessness.

Local Housing System Engagement

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

BHRS will continue to partner closely with Marin County's Division of Homelessness and Coordinated Care, which acts as host for the Marin County CoC, to utilize existing referral pathways and expand outreach to individuals eligible for BHSA Housing Interventions.

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

Local CoC

BHRS will collaborate with Marin's CoC by providing direct referrals to Coordinated Entry and support clients through the process of securing housing.

Public Housing Agency
Partner with the Marin Housing Authority to maximize use of federal and local rental assistance. BHRS will provide coordinated supportive services to clients who are homeless or at-risk of homelessness. BHRS will assist in maintaining housing stability through supporting clients in finding and maintaining housing, verifying eligibility for clients being considered for vouchers, and navigating housing voucher bureaucracy via Shelter+Care.

MCPs
BHRS will leverage MCPs transitional rent and Enhanced Case Management services to serve clients who are homeless or at-risk of homelessness, reduce duplication of services, and expand reach. BHRS will collaborate with MCPs on referral tracking, utilization of MCP benefits, and monitoring outcomes.

ECM and Community Supports Providers
BHRS will align services to ensure ECM work in collaboration with BHRS clinicians, FSPs, and peers to provide team-based care. BHRS will work with ECM and Community Support Providers to create referral protocols where providers can refer individuals with unmet behavioral health needs to BHRS and conversely BHRS can connect eligible clients to providers for housing supports.

Other (e.g., CalWORKS/TANF housing programs, child welfare housing programs, PSH developers and providers, etc.)
BHRS will continue its partnership with CFS to identify youth at risk of homelessness and connect them to BHSA housing resources. BHRS will partner with nonprofit housing developers to integrate BHRS services into new PSH projects.

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?
The County Behavioral Health System was the primary applicant on Marin's Homekey+ application with Catholic Charities of S.F. as the co-applicant. Marin BHRS committed to fund supportive services as well as rental and operating subsidies. In addition, BHRS plans to contract with Catholic Charities of S.F. for Specialty Mental Health Services onsite as well to promote a seamless service experience. Referrals for BHSA eligible individuals who are chronically homeless will be priorities through Coordinated Entry while up to three units may be filled with individuals who are at-risk of homelessness who will be prioritized through BHRS with a focus on those leaving incarceration or institutional settings.

Did the county behavioral health system receive Homeless Housing Assistance and Prevention Grant Program (HHAP) Round 6 funding?
No

BHSA Housing Interventions Implementation

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

Rental Subsidies (Chapter 7. Section C.9.1)
The intent of Housing Interventions is to provide rental subsidies in permanent settings to eligible individuals for as long as needed, or until the individual can be transitioned to an alternative permanent housing situation or rental subsidy source. (no action needed)

Is the county providing this intervention?
Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

How many individuals does the county behavioral health system expect to serve with rental subsidies under BHSA Housing Interventions on an annual basis?
Building up capacity and coordination with the Managed Care plans over the three year integrated plan period, we expect to be able to provide up to 22 local Behavioral Health "vouchers" by year <11* as well as support approximately 15 individuals per year in SLE settings offsetting rental costs. Currently the Marin Housing Authority has been in voucher shortfall for Section <11* since August 2024. Additionally, other voucher programs overseen by Marin Housing Authority that could serve this population, including Section 811 Mainstream and Shelter Plus Care have had limited availability. In addition, for project-based bundled rental and operating subsidies we will support 80 PSH units through the housing component as well as roughly 21 scattered site units, and 45 transitional units.

How many of these individuals will receive rental subsidies for permanent housing on an annual basis?
126

How many of these individuals will receive rental subsidies for interim housing on an annual basis?
50

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?
The numbers stated above are the estimated number of individuals who will receive subsidies in the first year of the integrated plan. We anticipate the number to grow to 200 for number of individuals served in BHSA funded Term-limited settings in year 2 (including the Peer Respite program and BHBH programs that will be transitioned to BHSA) and 163 individuals served in non-time limited settings with the expansion of the Flex Pool and more individuals who will have utilized their initial 6 months with the managed care plan funding.

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: 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)
Time Limited Interim Settings: Hotel and motel stays
Time Limited Interim Settings: Non-congregate interim housing models
Time Limited Interim Settings: Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls)[134] (does not include behavioral health residential treatment settings)
Time Limited Interim Settings: Peer respite

Will this Housing Intervention accommodate family housing?
Yes

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
This intervention provides non–time-limited rental subsidies in a variety of permanent housing settings to eligible individuals living with serious mental illness or co-occurring conditions. The goal is to ensure that cost is never a barrier to housing stability, thereby promoting recovery, independence, and long-term wellness. Subsidies are provided for as long as needed, or until the individual transitions successfully to

another permanent housing resource or alternative rental subsidy. Expected outcomes include increased housing stability, reduced homelessness, and improved behavioral health outcomes. By leveraging BHSA funds alongside federal, state, and local resources, this intervention maximizes impact while ensuring individuals have the housing and supports necessary for long-term stability.

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?
Project-based
Tenant-based

How will the county behavioral health system identify a portfolio of available units for placing BHSA eligible individuals, including in collaboration with other county partners and as applicable, Flex Pools (e.g., Master Leasing)? Please include partnerships and collaborative efforts your county behavioral health system will engage in
In the last five years of MHSA, Marin County BHRS has built up a number of different PSH for individuals who are BHSA eligible. In addition, BHRS plans to expand capacity with their contracted scattered-site housing provider through BHSA Housing Funds. BHRS collaborates closely with the Homelessness and Coordinated Care division of Marin County HHS who is charged with overall coordination of Marin County's homelessness response and prevention efforts, leading county-wide collaboratives with relevant parties.

Total number of units funded with BHSA Housing Interventions per year
116

Please provide additional details to explain if the county is funding rental subsidies with BHSA Housing Interventions that are not tied to a specific number of units
Approximately 22 people will receive tenant-based subsidies rather than project-based subsidies. In that case they are not tied to a specific number of units.

Operating Subsidies (Chapter 7, Section C.9.2)

Is the county providing this intervention?
Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

Anticipated number of individuals served per year
169

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
This intervention will provide operating subsidies to ensure the financial sustainability of housing programs serving individuals with serious behavioral health conditions. Operating subsidies will cover the gap between the actual costs of operating housing and the revenue generated, ensuring programs remain viable, stable, and accessible. BHSA Housing Interventions funding will be used to support a range of eligible costs, including building operations, property management, and staffing necessary for tenancy support. Through BHSA Housing Interventions funding, operating subsidies will provide ongoing financial support essential to maintaining both permanent and interim housing options, ensuring that individuals with behavioral health needs have consistent access to safe, affordable, recovery-oriented housing. This includes PSH, Peer Respite, and transitional housing.

For which setting types will the county provide operating subsidies?
Non-Time-Limited Permanent Settings: Apartments, including master-lease apartments
Non-Time-Limited Permanent Settings: Supportive housing
Non-Time-Limited Permanent Settings: Shared housing
Time Limited Interim Settings: Hotel and motel stays
Time Limited Interim Settings: Peer respite
Time Limited Interim Settings: Non-congregate interim housing models

Will this be a scattered site initiative?
No

Will this Housing Intervention accommodate family housing?
No

Total number of units funded with BHSA Housing Interventions per year
116

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)

Is the county providing this intervention?
No

Please explain why the county is not providing this intervention
This service is funded by BHBH funding through FY26/27. The County will use BHBH funding in FY26/27 rather than BHSA Housing. At this point Landlord Outreach and Mitigation funding has not prioritized as a BHSA Housing component program due to limited funding. However, if it proves to be a valuable priority under BHBH, this might be added in an annual update.

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

Is the county providing this intervention?
No

Please explain why the county is not providing this intervention
We will be utilizing BHBH funding for this service instead of BHSA Housing and learning from the implementation and utilization of this service under BHBH prior to committing any BHSA funds. At this point Participant Assistance Funds have not been prioritized as a BHSA Housing component program due to limited funding.

Housing Transition Navigation Services and Tenancy Sustaining Services (Chapter 7, Section C.9.4.3)
Pursuant to Welfare and Institutions (W&I) Code section 5830, subdivision (c)(2) **, BHSA Housing Interventions may not be used for housing services covered by Medi-Cal MCP. Please select Yes only if the county is providing these services to individuals who are not eligible to receive the services through their Medi-Cal MCP (no action needed)**

Is the county providing this intervention?
No

Please explain why the county is not providing this intervention
This service is funded by both the Managed Care Plans and by BHBH funding. The County will use BHBH funding in FY26/27 rather than BHSA Housing. At this point Housing Transition Navigation Services and Tenancy Sustaining Services funding has not prioritized as a BHSA Housing component program due to limited funding and the availability of MCP covered benefits. After the first three-year plan period BHRS will have more data and understanding of how the MCPs in Marin are providing this benefit and whether

additional funding allocated to this category should be a priority.

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

Is the county providing this intervention?
Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

Anticipated number of individuals served per year
250

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Engage unserved individuals experiencing homelessness in the behavioral health system so that they may receive the appropriate services. Provide peer outreach and engagement from individuals with lived experience who work to engage and build trust with individuals experiencing homelessness who potentially have a serious mental illness.

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

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

Is the county providing this intervention to chronically homeless individuals?
Yes

How many capital development projects will the county behavioral health system fund with BHSA Housing Interventions?
1

Capital Development Project

Capital Development Project Specific Information
Please complete the following questions for each capital development project the county will fund with BHSA Housing Interventions

Name of Project
Carmelita House PSH (Homekey+)

What setting types will the capital development project include?
Non-Time-Limited Permanent Settings: Supportive housing

Capacity (Anticipated number of individuals housed at a given time)
9

Will this project braid funding with non-BHSA funding source(s)?
Yes

Total number of units in project, inclusive of BHSA and non-BHSA funding sources
9

Total number of units funded with Housing Interventions funds only
0

Please provide additional details to explain if the county is funding capital development projects with BHSA Housing Interventions that are not tied to a specific number of units
N/A

Anticipated date of unit availability (Note: DHCS will evaluate unit availability date to ensure projects become available within a reasonable timeframe)
3/1/2027

Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000)
170213

Have you utilized the "by right" provisions of state law in your project?
Yes

Other Housing Interventions

If the county is providing another type of Housing Interventions not listed above, please describe the intervention
None

Is the county providing this intervention to chronically homeless individuals?
No

Anticipated number of individuals served per year
0

Continuation of Existing Housing Programs

Please describe if any BHSA Housing Interventions funding will be used to support the continuation of housing programs that are ending (e.g., Behavioral Health Bridge housing)
Yes, BHSA Housing Intervention funding will be used to continue BHBH programs in years 2 and 3 of this integrated plan.

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

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

Which of the following housing-related Community Supports is the county behavioral health system an MCP-contracted provider of?
None of the Above

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

Housing Transition Navigation Services
Undecided

Housing Deposits
Undecided

Housing Tenancy and Sustaining Services
Undecided

Short-Term Post-Hospitalization Housing
No

Recuperative Care
No

Day Habilitation
No

Transitional Rent
Undecided

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)?**
Marin County Behavioral Health and Recovery Services (BHRS) and Housing and Community Connections (HCC) will identify and refer Medi-Cal members in need of Community Supports (CS) in accordance with CalAIM referral requirements. Upon referral, BHRS and HCC staff will collaborate with a contracted provider designated to verify eligibility for housing-related Community Supports. This provider will review each referred individual's Medi-Cal enrollment status, CalAIM eligibility criteria, and documentation confirming medical necessity for housing-related CS.
Eligible members will then be connected to the appropriate CS program based on service availability, member preference, and alignment with MCP referral and authorization protocols. Coordination among BHRS, HCC, and the contracted eligibility verification provider will ensure timely confirmation of eligibility and linkage to housing-related supports.

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
HCC, in partnership with BHRS and other HHS divisions, will be convening a homelessness CalAIM working group to ensure that there is awareness of all currently funded ECM and CS programs in Marin between the

County and all CBOs.

Does the county behavioral health system track which of its contracted housing providers are also contracted by MCPs for housing-related Community Supports (provided in questions #1 and #2 above)?
No

What processes does the county behavioral health system have in place to ensure Medi-Cal members living with significant behavioral health conditions do not experience gaps in service once any of the MCP housing services are exhausted, to the extent resources are available?
Most individuals with significant behavioral health conditions are also connected to BHRS' FSPs or through support from housing-based case managers under HCC's homelessness response system.

Flexible Housing Subsidy Pools

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

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

Is there an operating Flex Pool (or elements of a Flex Pool, which includes (1) coordinating and braiding funding streams, (2) serving as a fiscal intermediary, (3) identifying, securing, and supporting a portfolio of units for participants, and/or (4) coordinating with providers of housing supportive services) in the county (please refer to DHCS' Flex Pools TA Resource Guide)?
No

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

What role does the county behavioral health system plan to have in the Flex Pool?
Funder

Have you identified an Operator of the Flex Pool?
No

Does the county plan to administer some or all Housing Interventions funds through or in coordination with the Flex Pool?
Yes

Which Housing Interventions does the county plan to administer through or in coordination with the Flex Pool?
Rental Subsidies

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
Marin will release an RFP to identify an Operator of the Flex Pool.

Behavioral Health Services Fund: Innovative Behavioral Health Pilot and Projects

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

Does the county's plan include the development of innovative programs or pilots?
No

Workforce Strategy

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

Maintain an Adequate Network of Qualified and Culturally Responsive Providers

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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:

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**

Meets federal and state standards **for timely access to care and services, considering the urgency of the need for services.**

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

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

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

Build Workforce to Address Statewide Behavioral Health Goals

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

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Assess Workforce Gaps

What is the overall vacancy rate for permanent clinical/direct service behavioral health positions in the county (including county-operated providers)?
17

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

For county behavioral health (including county-operated providers), please select the five positions with the greatest vacancy rates
Other qualified provider
Licensed Clinical Social Worker
Licensed Marriage and Family Therapist
Licensed Professional Clinical Counselor
Medi-Cal Certified Peer Support Specialist

Please describe any other key workforce gaps in the county
Unfortunately, the behavioral health positions listed above do not fully align with the job classifications in Marin County (e.g., Marin's job classification of Licensed Crisis Specialist can be held by a LCSW, a LMFT, or a LPCC). The job classifications in Marin with the highest vacancy rates are Social Service Worker II Bilingual, Social Service Worker II, and Licensed Crisis Specialist. The most challenging gap has historically been with our Crisis Specialist assisting with coverage during off-hours. Currently based on data our biggest gap has been with language access and positions that support that.

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)?
Due to the implications of Proposition 1, the workforce is expected to undergo significant changes. This division will be responsible for identifying essential service areas and determining which functions may need to be reduced as a result of limited funding. At the same time, a key strategy will focus on preserving as many positions as possible, with the goal of avoiding layoffs.

BHRS will meet anticipated workforce needs through a combination of County-operated and contracted services. Based on our projections for FSP ICM and FSP ACT/FACT levels of service, our current workforce generally matches the needs of the new program requirements. We intend to merge two of our existing FSPs to a single large ACT/FACT team, so we anticipate a shift of some of our clinical and supervisory positions. For example, the two current FSP teams each have a Unit Supervisor, but only one will be required for the large ACT/FACT team. We are exploring the creation of clinical lead positions to help manage the workload and ensure ACT/FACT fidelity is met. The department expects a significant increase in administrative demands associated with BHSA. Due to the fiscal impacts of BHSA, BHRS has implemented several strategies to address the resulting funding gap, including the attrition of vacant and fixed-term positions that previously provided essential administrative support. BHRS will continue to evaluate and adjust its workforce needs over the next three years.

Over the next three fiscal years, Marin County will need to train and retain its behavioral health workforce. Despite fiscal constraints, Marin will focus on leveraging state workforce initiatives, strengthening local training pipelines, and enhancing retention strategies to build a sustainable behavioral health workforce. BHRS will leverage no-cost Centers of Excellence training and technical assistance to support implementation of and to ensure fidelity to EBPs across county and contracted 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.

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

Please explain any actions or activities the county is engaging in to leverage the program
Marin will advertise opportunities and encourage staff to apply.

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

Please explain any actions or activities the county is engaging in to leverage the program
Marin will advertise opportunities and encourage staff to apply.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Recruitment and Retention Program?
No

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

Please explain any actions or activities the county is engaging in to leverage the program
Marin will advertise opportunities and encourage staff to apply.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Residency Program?
No

Please describe any other efforts underway or planned in the county to address workforce gaps aside from those already described above under Behavioral Health Services Act Workforce, Education, and Training
Marin will leverage state workforce initiatives, pursue innovative local training and pipeline partnerships, and strengthen retention strategies to address workforce gaps.

Budget and Prudent Reserve

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

Budget and Prudent Reserve

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

Please upload the completed budget template
Integrated-Plan-Budget-Template_v3c_Marin-UPDATED 5.27.26.xlsx

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

Behavioral Health Services and Supports (BHSS)
N/A - we are already below the new 20% reserve limit.

Full Service Partnership (FSP)
N/A - we are already below the new 20% reserve limit.

Housing Interventions
N/A - we are already below the new 20% reserve limit.

Enter date of last prudent reserve assessment
5/27/2026

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

BHSS

N/A - we are already below the new 20% reserve limit.

FSP

N/A - we are already below the new 20% reserve limit.

Housing Interventions

N/A - we are already below the new 20% reserve limit.

Plan Approval and Compliance

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

Behavioral health director certification

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

Please upload the completed Behavioral health director certification template
Marin County Behavioral Health Director Certification Signed.pdf

County administrator or designee certification

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

Please upload the completed County administrator or designee certification template
County_Administrator_or_Designee_Certification_Template signed.pdf

Board of supervisor certification

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

Please upload the completed Board of supervisor certification template

12.09.25 BHRS BHSA IP BOS Certification - Signed.pdf

Confirm that the data is up to date and reflects the correct information for a Final Plan

Data Suppression Notice:

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

Uploaded Documents

1. Marin_FY 25-26 Integrated Quality Improvement Workplan
2. BHSA Community Planning Process Demographics and Feedback
3. Marin Independent Journal BHSA Legal Notice.pdf
4. BHSA Public Comment and Hearing HHS Socials 1.pdf
5. BHSA Public Comment and Hearing HHS Socials 2.pdf
6. BHSA Public Comment and Hearing HHS Socials 3.pdf
7. BHSA Public Comment and Hearing HHS Socials 4.pdf
8. BHSA Public Comment and Hearing Screenshot.pdf
9. Integrated-Plan-Budget-Template_v3c_Marin-UPDATED 5.27.26.xlsx
10. Marin County Behavioral Health Director Certification Signed
11. County_Administrator_or_Designee_Certification_Template signed
12. 12.09.25 BHRS BHSA IP BOS Certification – Signed.pdf

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COUNTY OF MARIN

QAPI

Quality Assurance & Performance Improvement Work Plan
FY 2025-2026

Health & Human Services Department
Behavioral Health and Recovery Services Division
Todd Schirmer, PhD, CCHP, Behavioral Health Director

Quality Management Program

The Marin Behavioral Health and Recovery Services Division (BHRS) Quality Management (QM) program is responsible for monitoring effectiveness, providing support, and conducting performance monitoring activities which include: utilization management, utilization review, provider appeals, credentialing and monitoring, resolution of beneficiary grievances, and analysis of beneficiary and system outcomes. The QM program's activities are guided by federal and state regulations, including Title 42 of the Code of Federal Regulations, California Code of Regulations Title 9, California Welfare and Institutions Code, as well as BHRS' integrated contract with the California Department of Health Care Services (DHCS).

The **Utilization Management (UM) Team**, a component of the QM program assures that beneficiaries have appropriate access to specialty mental health and substance use treatment services. Program activities include: the evaluation of medical necessity determinations, and continuous monitoring of the appropriateness and efficiency of services.

The **Administrative Operations Committee** is led by Operations and Administrative representatives. The BHRS Operations Director and Administrative Services Manager (ASM)take primary responsibility for setting the agendas and sponsoring the work of the committee to identify and problem-solve issues across the BHRS system that relate to the Electronic Health Record (EHR) system, the practice management system, policies and procedures, documentation processing, credentialing and onboarding and other administrative tasks that are essential to the integrity of BHRS operations.

The **Quality Improvement (QI) Team**, monitors the overall service delivery system with the aim of improving care provision and increasing consumer and family member satisfaction and outcomes. QI is also responsible for the ongoing implementation of the Federal Managed Care Final Rule, including the Provider Directory, Network Adequacy submissions and other related documents.

The **Quality Improvement Committee** (QIC) is a combined mental health (MH) and substance use services (SUS) committee, and is comprised of a diverse group of stakeholders, including representatives from MH and SUS administration and clinical programs, the Behavioral Health Board,

peers/family members, the Patient Rights Advocate, and contractors/community partners from both MH and SUS agencies. Quarterly QIC meetings include findings from a range of compliance and quality improvement activities, and obtain input into these and other areas for improvement.

The **Incidence and Grievance Subcommittee** of the QIC is attended by the Medical Director, QI Coordinator, QM Division Director, Adult Services Division Director, Youth and Family Division Director, Substance Use Division Director, Program Manager Crisis Continuum of Care, Program Manager Adult Services, Program Manager for Substance Use Services, and on ad hoc basis Program Supervisors. It meets quarterly to evaluate and analyze trends of grievances, appeals, fair hearings, and unusual occurrences to identify issues or trends that require implementation of system changes. It also makes improvement recommendations. Findings from this meeting are presented to the QIC stakeholders as required.

The **Policy and Procedure Subcommittee meets** as needed to draft and/or update new or existing policies and procedures.

The **Equity and Community Partnerships Committee (ECPC)** which is comprised of BHRS management and staff, contract agency providers, consumer advocates, consumers, community leaders and stakeholders. There are working subcommittees within the Board responsible for discrete content areas such as training, policies, and access. The 20+-member board is tasked to analyze data, review existing improvement plans, examine practice approaches and make recommendations related to policy, service delivery, staffing and training needs, and system improvements.

Quality Assessment and Performance Improvement Work Plan

The Quality Assurance and Performance Improvement Work Plan creates systems whereby improvement related data is available in an easily interpretable and actionable form. The QAPI Work Plan is evaluated and updated annually. The elements of this Work Plan are informed by the quality improvement requirements BHRS' integrated contract as well as feedback received from the External Quality Review and DHCS Annual and Triennial audit findings.

I) Access To Care

1) Network Adequacy: 274 Compliance

Goal/Requirement	Programs involved	Actionable Items	Measurement
Report and assess Network Adequacy including submitting 274 files every month. Further, The IBHP will work towards adding Day Rehabilitation Service to the 274 report	- EHR team - SUD - QM	Contract with a facility to provide Day Rehabilitation services, and continue to submit 274 files on time with accurate information	Add Day Rehabilitation Service to the 274 report.

2) After hours services

Goal/Requirement	Programs involved	Actionable Items	Measurement
Monitor and meet metrics to measure performance of after hours care; Crisis Stabilization Unit, Mobile Crisis response, 24/7 Access hotline	- SUD - QM - CSU - Access	Continue quarterly dashboard and data sharing to track performance of after hour services. Report performance at quarterly Quality Improvement Committee meeting Adapt goals and interventions to improve metrics as needed.	Maintain accepted levels of After Hour services as measured by our KPIs: # of total contacts and Dispatch – Response time Continue presenting information in quarterly Quality Improvement Committee meeting

3) Access phoneline

Goal/Requirement	Programs involved	Actionable Items	Measurement
1. Conduct test calls (including in languages other than English) Ensure that test calls are conducted during and after business hours 2. Reduce percent of all calls that go voicemail 3. Ensure calls meet DHCS requirements 100% of the time	- MH - SUD - Access	Improve the number of Test calls answered live from current average of 50%. Test calls are appropriately logged 100% of the time Reorganize Access team staffing to increase staff available to answer calls Analyze percent of all calls that go to voicemail so that we can lay the foundation for an improvement project near year Report test call results on the DHCS Quarterly 24/7 Access Line Report	Successfully complete all test calls requirements. Decrease the number of calls going to voicemail

4) Timeliness: Follow-up and time to first appointment

Goal/Requirement	Programs involved	Actionable Items	Measurement
1. Offer follow-up for those undergoing a course of treatment for non-urgent non-psychiatric MH services within 10 business days of first appointment. 2. Time from first contact to first appointment for SUD (10 days for routine care, 3 days for OTP)	- MH - SUD - Access	Improve the time to offer Follow-Up for those undergoing a course of treatment for Non-urgent non-psychiatric services Report time from first contact to first appointment quarterly at QIC	Reduce the average for the number of days for Non-urgent non-psychiatric follow up services 90% of kept first appointments are within guidelines for time from first contact

5) Timeliness: Provider tracking

Goal/Requirement	Programs involved	Actionable Items	Measurement
Improve timeliness tracking and reporting for contracted providers.	-SUD - MH	- Improve a process to identify which programs a timeliness document belongs to. - Create unified protocol for referrals to contracted providers. - Train referral partners on new protocol - Train providers how to use the timeliness form - Track completion quarterly - Discuss progress at site visits - Create program specific report for providers.	1. Create Protocol for referral process to contracted providers. 2. Create report to track timeliness documents by providers. 3. Reduce by 10% the number of incomplete timeliness forms for new clients at 90 days post first contact.

II) Care Coordination

1) Substance Use Treatment Perception Survey responses

Goal/ Requirement	Programs involved	Actionable Items	Measurement
Improve client's perception that their care is coordinated (at least physical health, mental health, and substance use domains at a minimum)	- SUD	Review quantitative and qualitative TPS responses related to Care Coordination and identify improvement projects	Discuss results at Provider Meeting and at SUD Admin staff meeting Determine at least one project for improvement

III) Beneficiary Rights and Satisfaction

1) Client Satisfaction

Goal/Requirement	Programs involved	Actionable Items	Measurement
Client Satisfaction Survey data (POQI and TPS) are reviewed, shared with providers, and used to identify internal or external performance improvement projects	- Quality Management - SUD	Review of response data with providers Identify areas for continuous quality improvement based on client data.	MH: Increase the overall number of POQI participants SUD: At least 50% of contracted providers have quality improvement projects related to client input.

2) Client grievances and appeals and Change of Provider Request

Goal/Requirement	Programs involved	Actionable Items	Measurement
Respond to client dissatisfaction indicators in a timely way and analyze these data for trends that may identify areas for improvement	- MH - SUD	Review grievances and appeals on a quarterly basis at the QIC meeting Review provider change requests, grievances and appeals quarterly with the grievance sub-committee to determine any feedback or policy revision and/or system changes.	Log and resolve all grievances and appeals in accordance with the timeframes identified by DHCS

IV) Documentation standards and compliance

1) Utilization Review – Clinical Documentation

Goal/Requirement	Programs involved	Actionable Items	Measurement
Improve quality of clinical documentation as evidenced by < 5% disallowance rates for 70% of programs reviewed during FY2526	- Quality Management - MH - SUD	Provide clinical documentation training to all new clinical staff within six months after hire	Decrease UR disallowance rate for programs with a prior disallowance rate > 5% to < 5% by conducting re-reviews and training for those programs/providers within 6 to 9 months from the date the initial report is disseminated

2 Utilization Review – Frequency and rate of review

Goal/Requirement	Programs involved	Actionable Items	Measurement
Review a minimum of 5% of billed medical records from every BHRS mental health and substance use program and contract provider program reviewed annually and provide UR results to provider	- Quality Management - MH - SUD	Provide completed reports to programs within 30 calendar days of the utilization review	Continue to review a minimum of 5% of billed services per program/ Agency. Conduct re-reviews of programs that have high disallowance rates (>5%) following UR review (>5%) within 6-9 months

3) Utilization Management –Monitor Safe and Effective Medication Practices

Goal/Requirement	Programs involved	Actionable Items	Measurement
1. Ensure that all clients who are prescribed medication have a current, signed medication consent form on file, including all required elements (and any required JV-220 forms), 100% of the time 2. Increase the number of medication consent forms received	- Quality Management	Develop a strategy to consistently notate and track client consent to medication in the client record in the new EHR	QM staff and Medical Director or designee will continue to conduct medication monitoring reviews for at least 5% of the medical records, including review of required consent forms and any JV-220 forms, if applicable

V) Cultural and Linguistic Competence and Humility

1) Cultural Humility Training compliance

Goal/Requirement	Programs involved	Actionable Items	Measurement
1. Improve cultural humility and sensitivity within the delivery system and increase awareness of disparities for populations based on race, ethnicity, age, and language (REAL) and sexual orientation and gender identity and expression (SOGIE)	- Quality Management - Equity and Inclusion Dept	- BHRS Equity and Inclusion Team will monitor Cultural Humility training hours completed to ensure that BHRS staff are in compliance	Provide at least 3 trainings to Marin County staff on Cultural Humility and Linguistic Competence Continue tracking providers who speak a language other than English per 274 reporting

VI) Performance Improvement Projects, Quality Improvement

1) PIP: FUA

Goal/Requirement	Programs involved	Actionable Items	Measurement
Improve substance use treatment follow up after an Emergency Department visit for a Substance Use reason	SUD	Continue current intervention of bilingual Recovery Coach assigned to clients in the ED. Work with CalMHSA to identify intervention(s) for new PIP cycle	At least one new intervention identified by June 2026

2) PIP: Timely Access (see also timeliness section above)

Goal/Requirement	Programs involved	Actionable Items	Measurement
Improve the number of new clients who receive their first non-urgent, non-psychiatric service within 10 business days of request	MH	Ensure that we provide sufficient training for assessments and focus on screening tools, and triaging to place clients in programs more quickly Adhere to no wrong door policy which allows clients to be seen for services prior to assessment being completed	Continue to meet PIP metrics regarding timeliness

3) MAT penetration for SUD clients

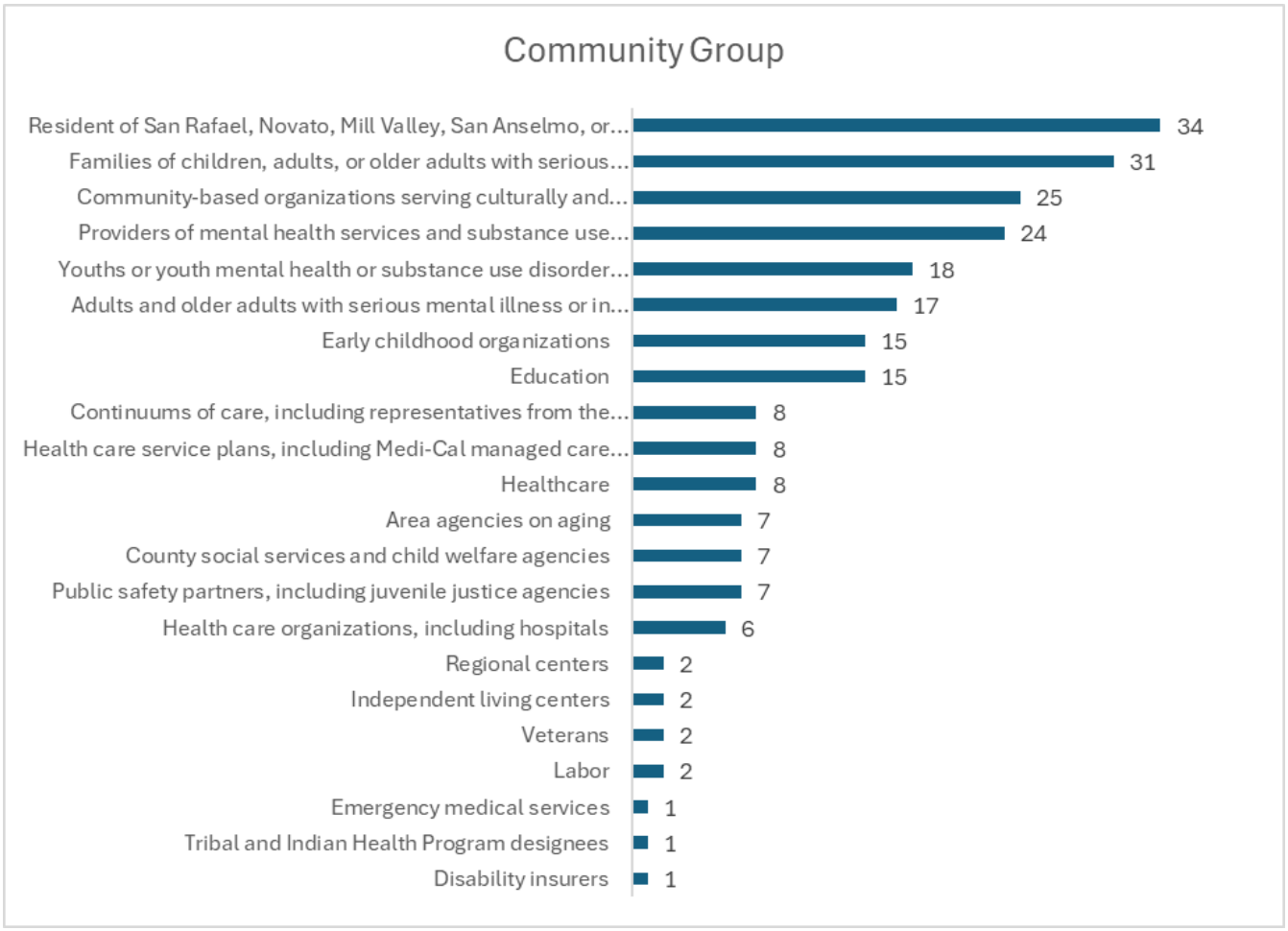
Goal/Requirement	Programs involved	Actionable Items	Measurement
Increase the percent of Substance Use clients who are also receiving Medications for Addiction Treatment (MAT)	SUD	- Incentivize providers to add more MAT prescribing capacity - Reduce stigma around MAT	% of SUD clients with opioid use disorder with MAT services in the year

Community Planning Sessions

From 11/14/2024 – 5/21/2025, 31 in-person and Zoom sessions (including Lived Experience [family and consumer], Older Adult, LGBTQ+, Early Childhood, BHRS Staff)

4 sessions held in Spanish, 1 in Vietnamese

192 participants, 106 completed demographics

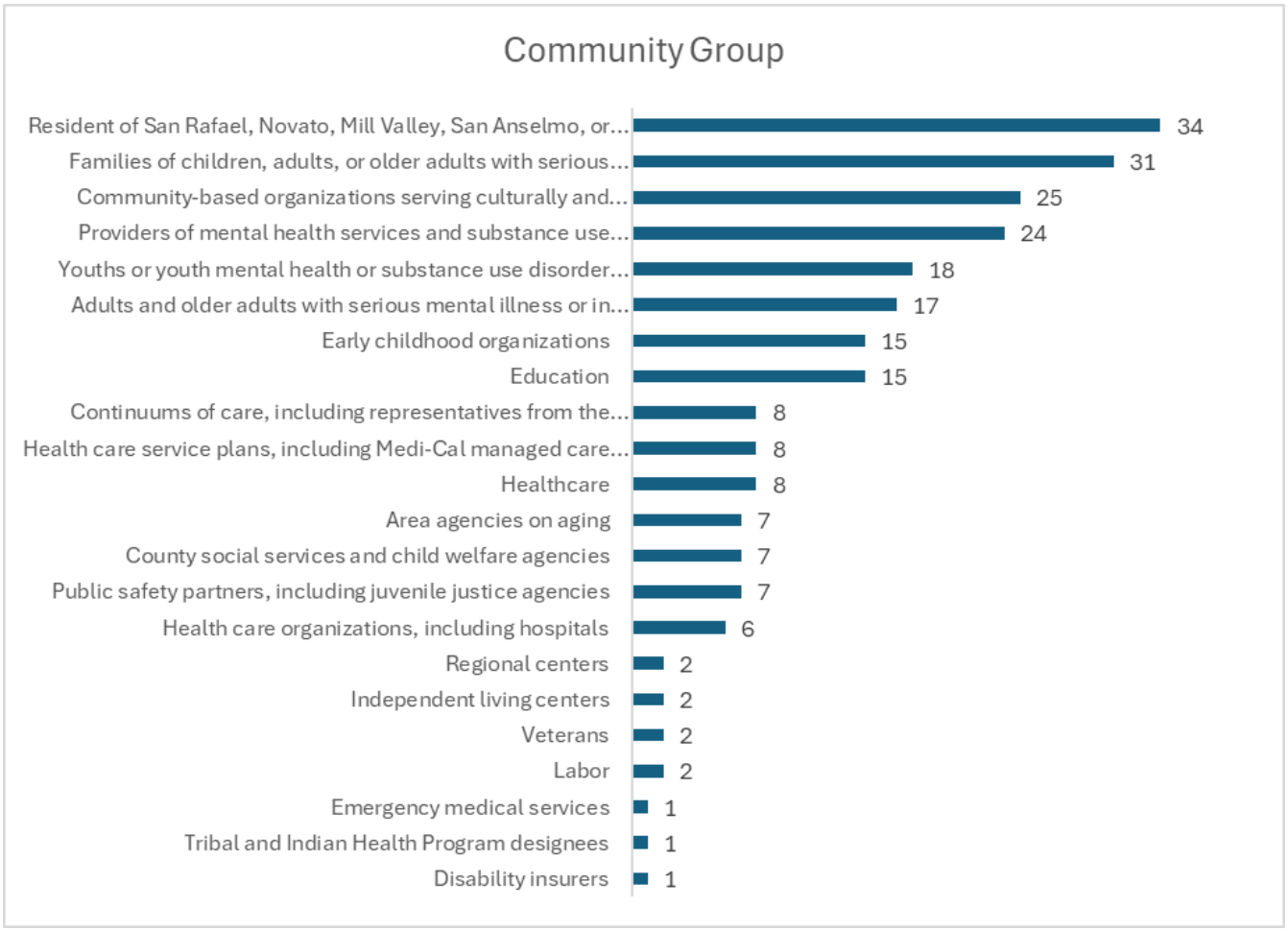


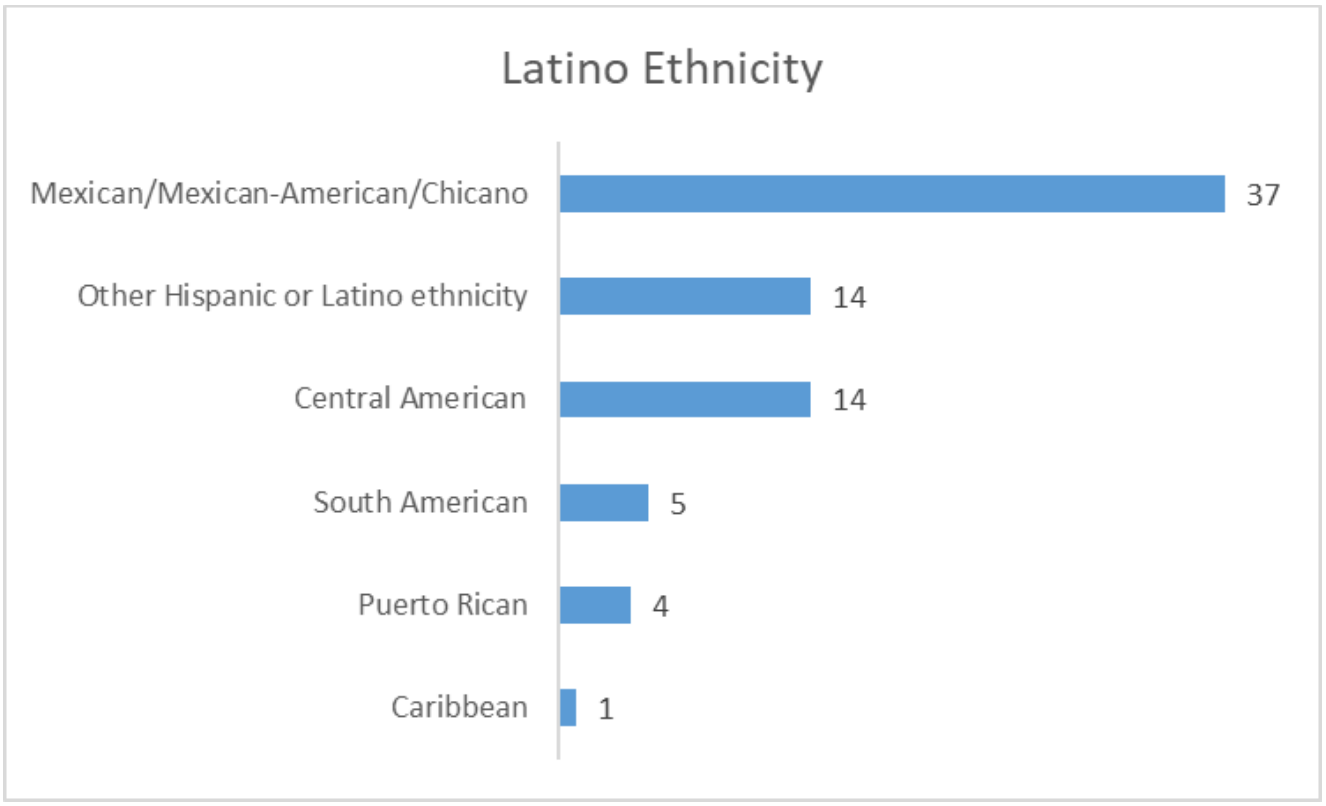
Community Planning Sessions

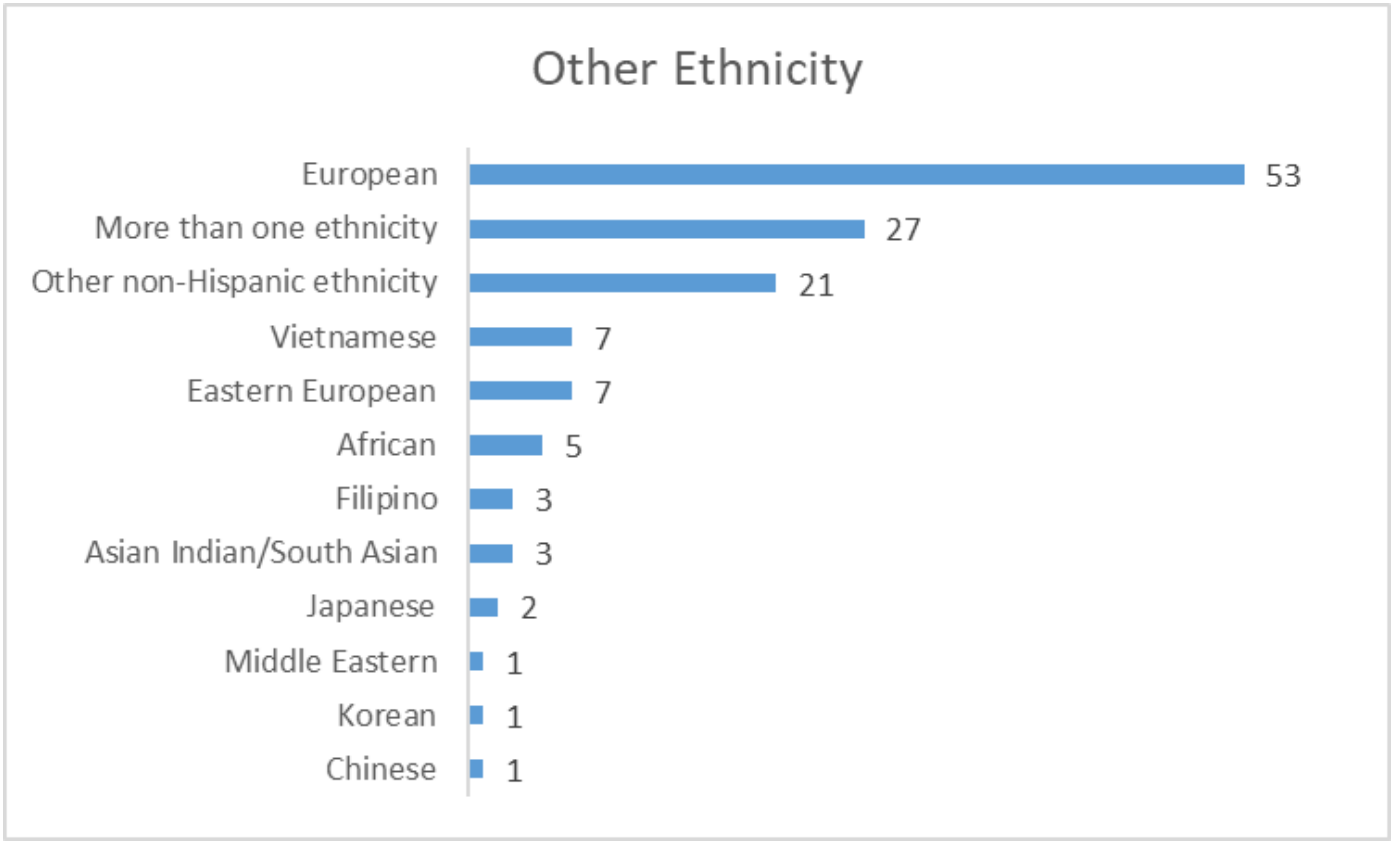
From 11/14/2024 – 5/21/2025, 31 in-person and Zoom sessions (including Lived Experience [family and consumer], Older Adult, LGBTQ+, Early Childhood, BHRS Staff)

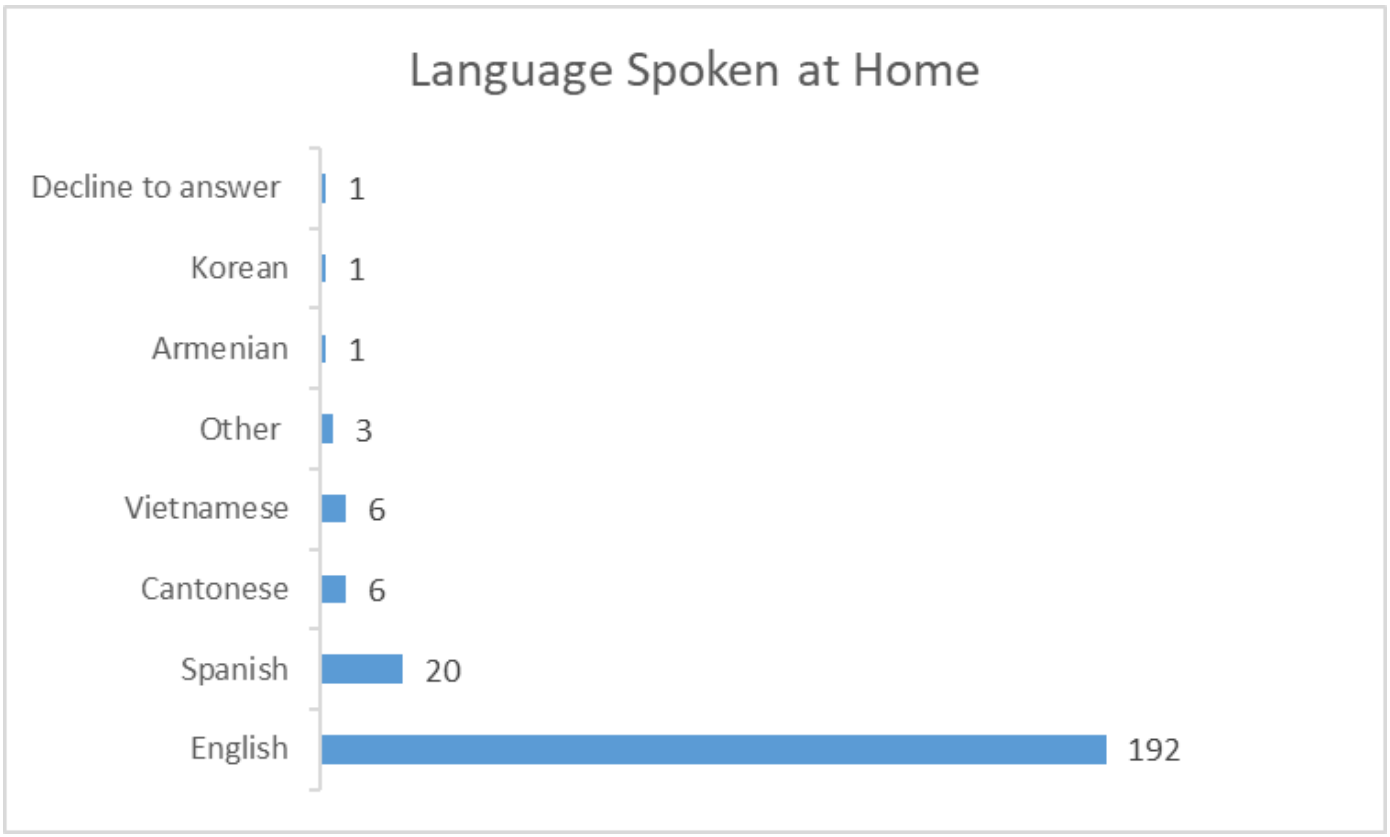
4 sessions held in Spanish, 1 in Vietnamese

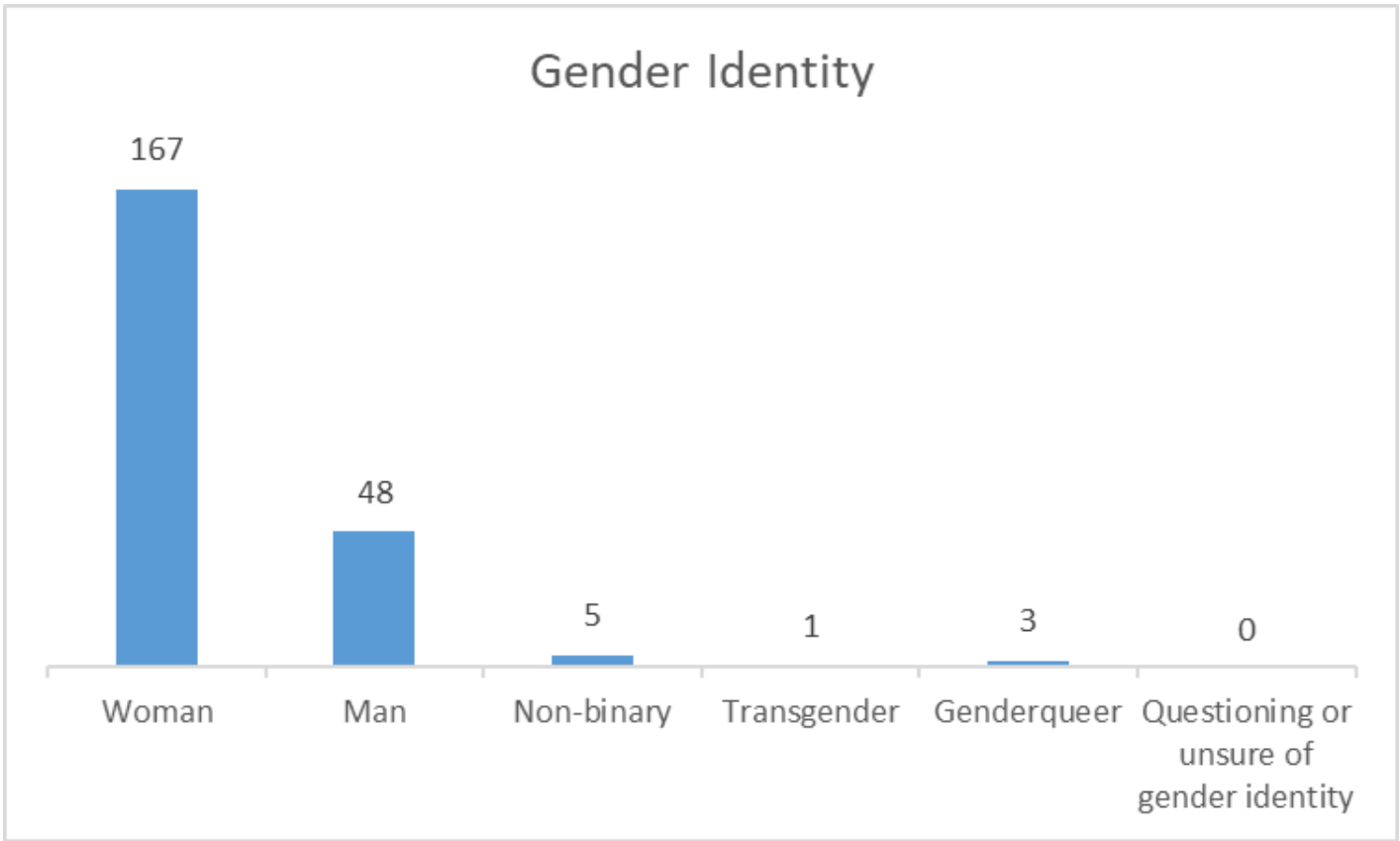
192 participants, 106 completed demographics

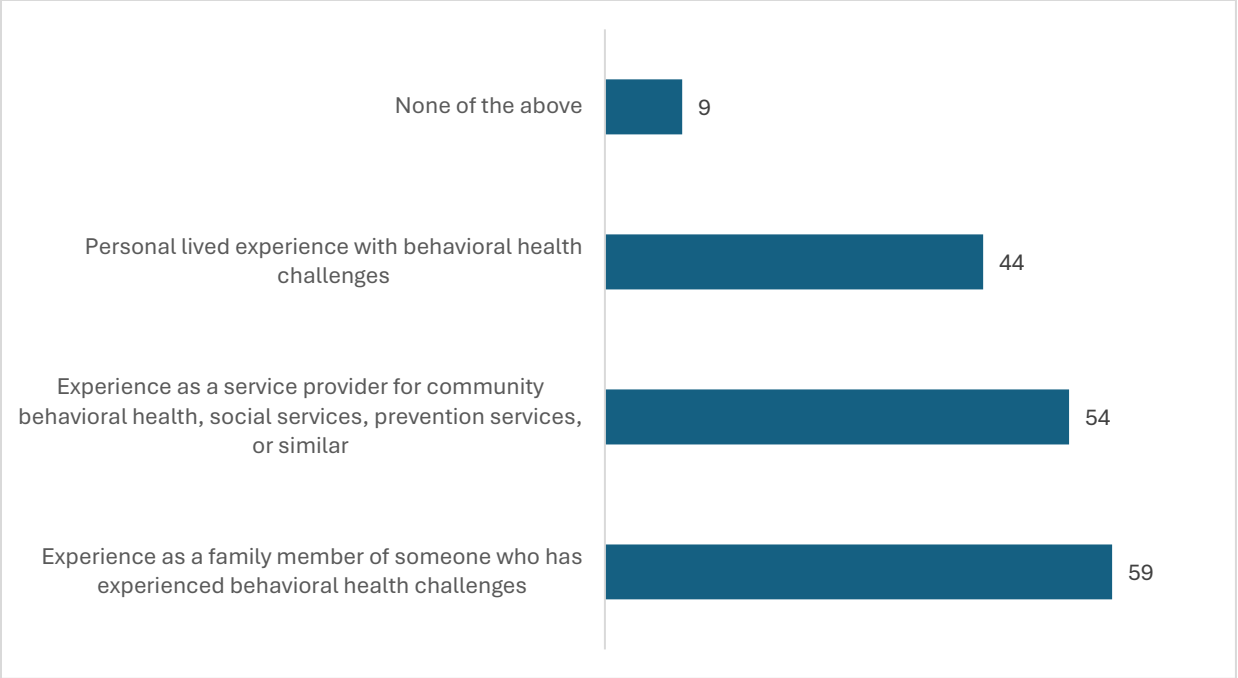


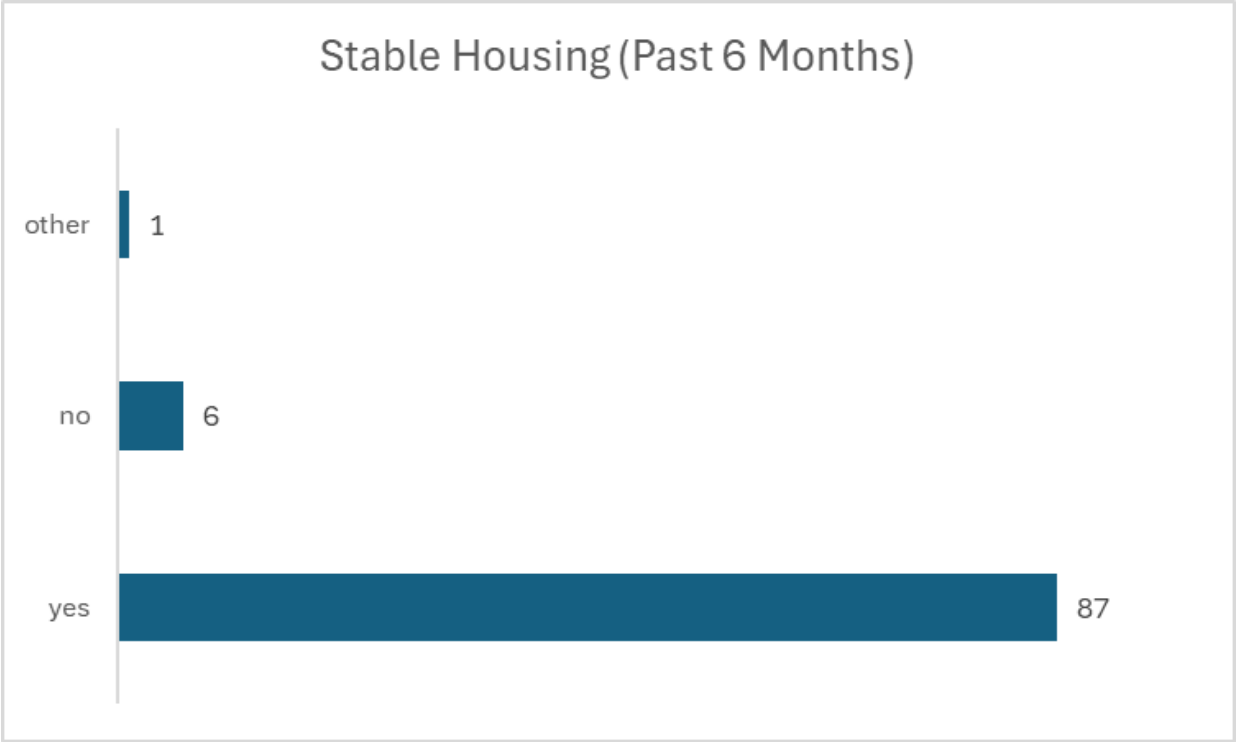

Latino Ethnicity
Mexican/Mexican-American/Chicano
37
Other Hispanic or Latino ethnicity
14
Central American
14
South American
5
Puerto Rican
4
Caribbean
1

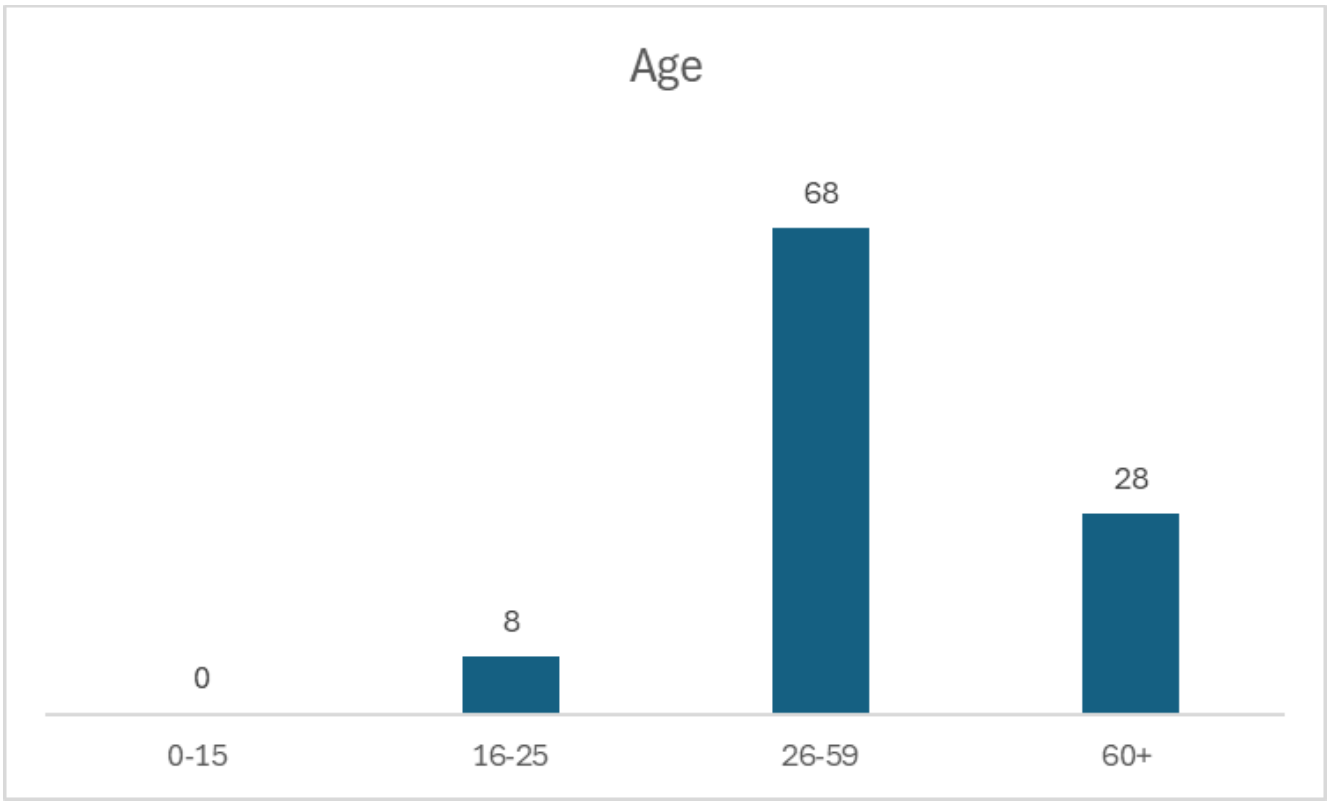

Other Ethnicity
European
53
More than one ethnicity
27
Other non-Hispanic ethnicity
21
Vietnamese
7
Eastern European
7
African
5
Filipino
3
Asian Indian/South Asian
3
Japanese
2
Middle Eastern
1
Korean
1
Chinese
1

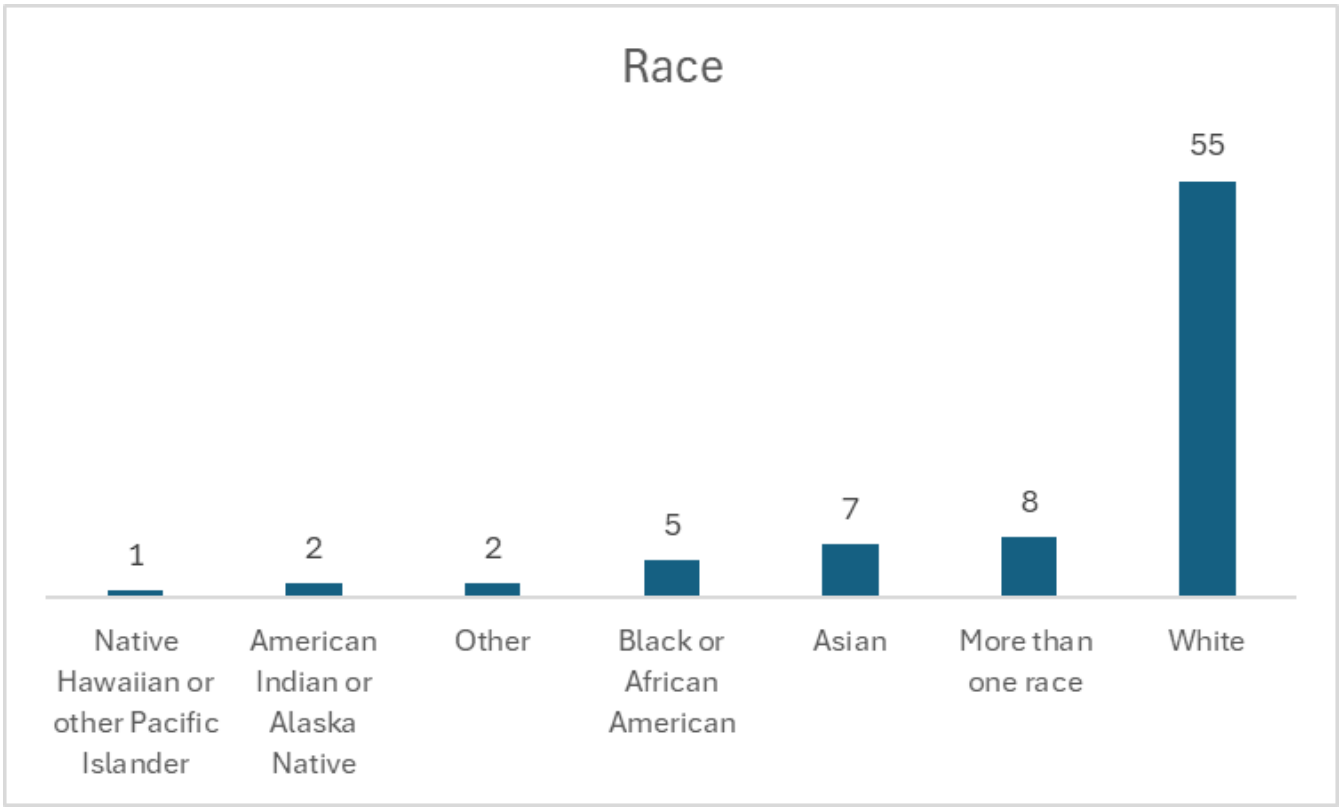

Language Spoken at Home
Decline to answer
1
Korean
1
Armenian
1
Other
3
Vietnamese
6
Cantonese
6
Spanish
20
English
192

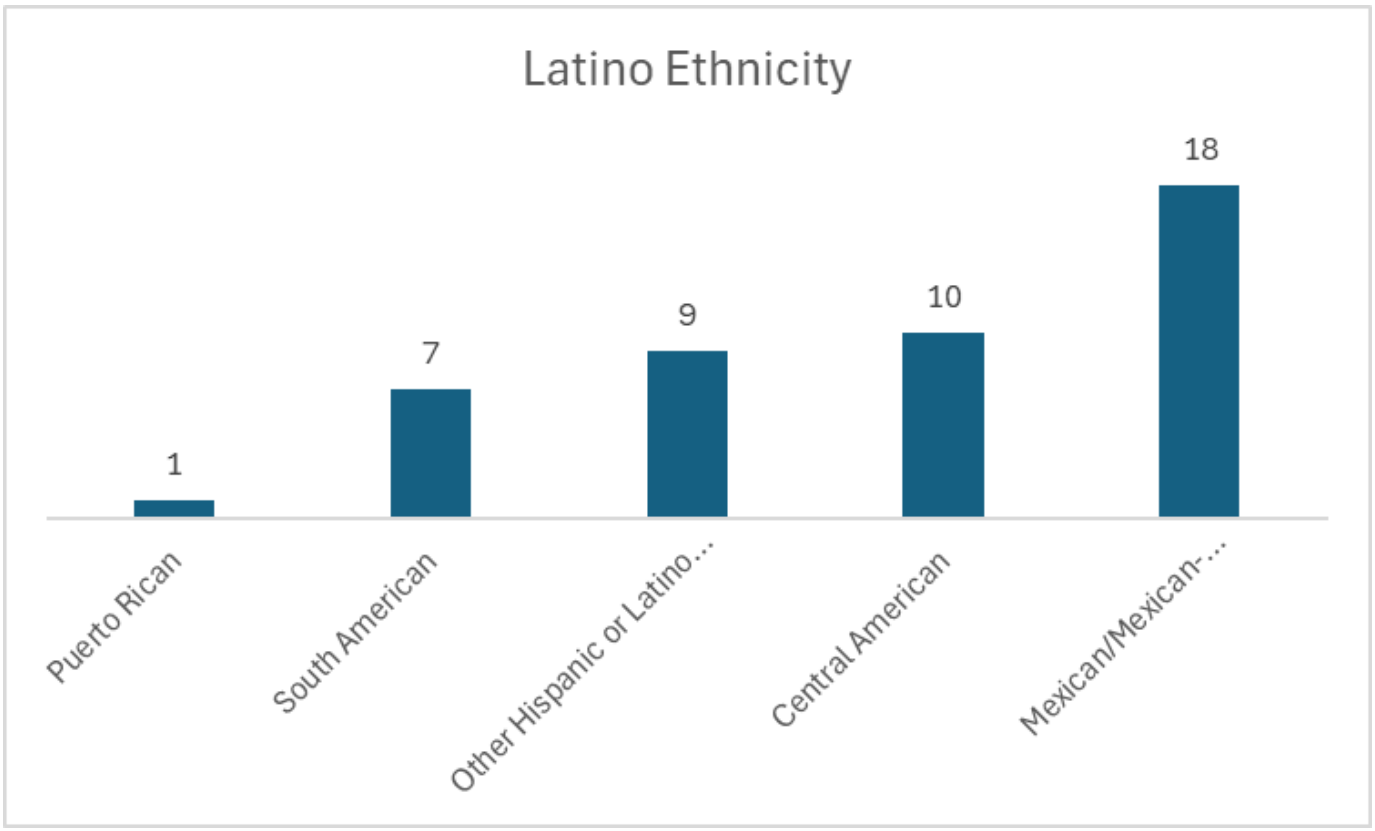

Gender Identity
167
48
5
1
3
0
Woman
Man
Non-binary
Transgender
Genderqueer
Questioning or unsure of gender identity

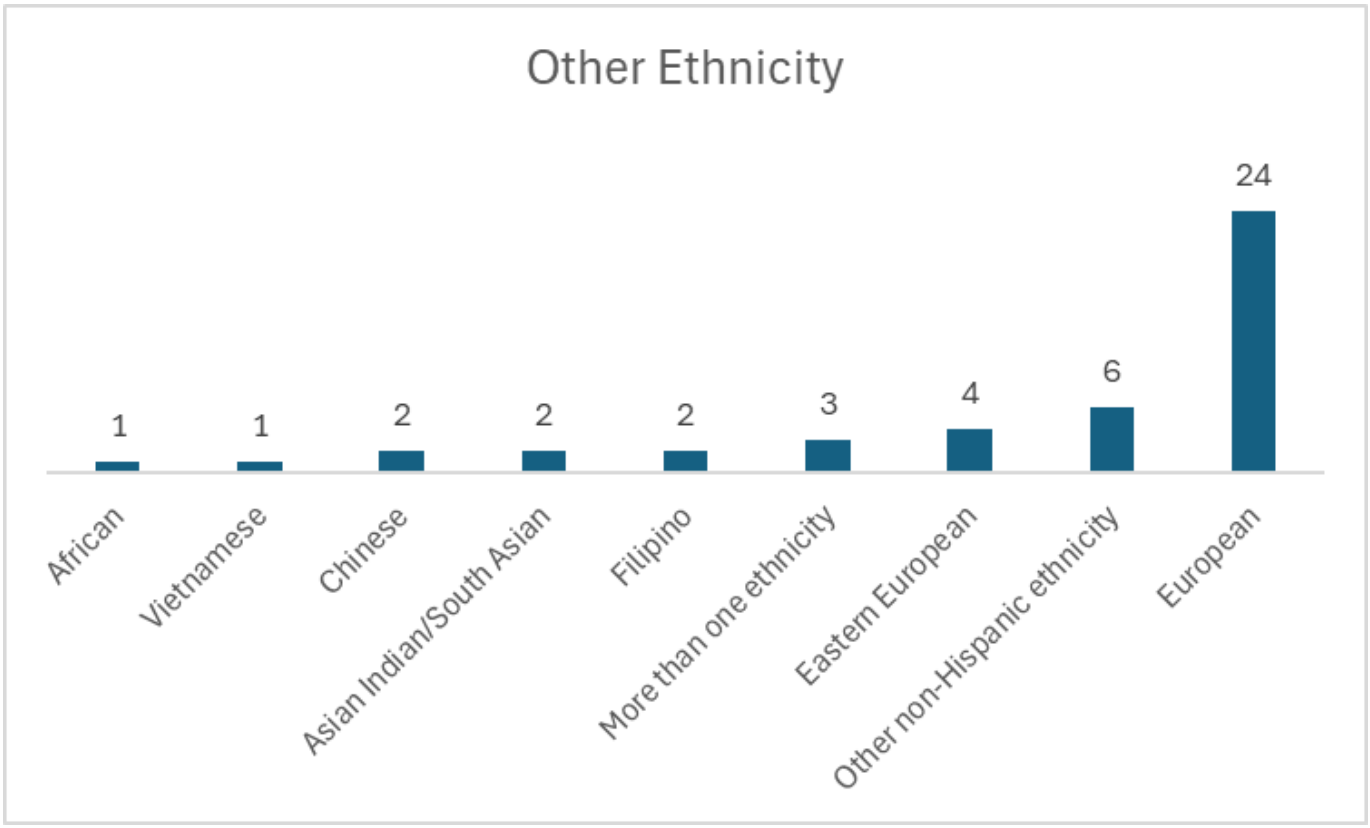

None of the above
9
Personal lived experience with behavioral health challenges
44
Experience as a service provider for community behavioral health, social services, prevention services, or similar
54
Experience as a family member of someone who has experienced behavioral health challenges
59

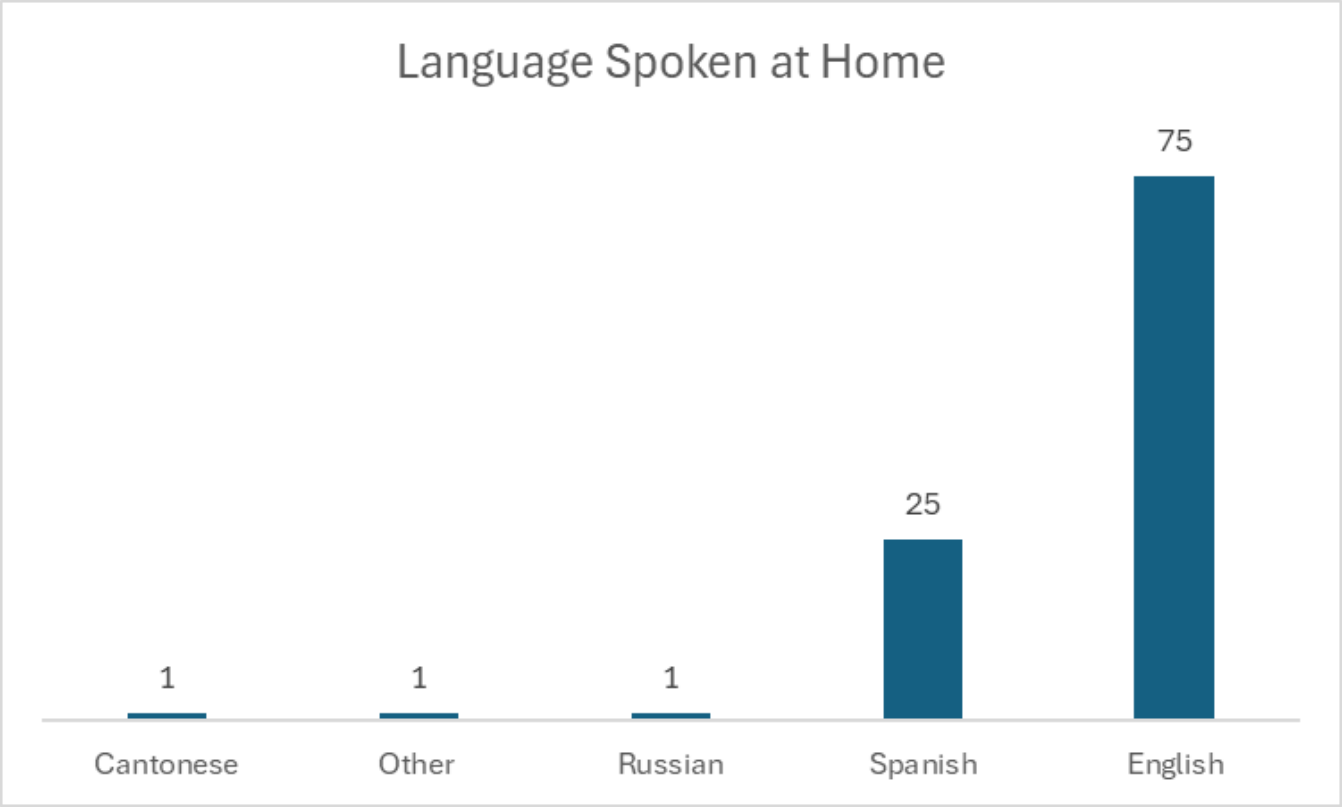

Stable Housing (Past 6 Months)
other
1
no
6
yes
87

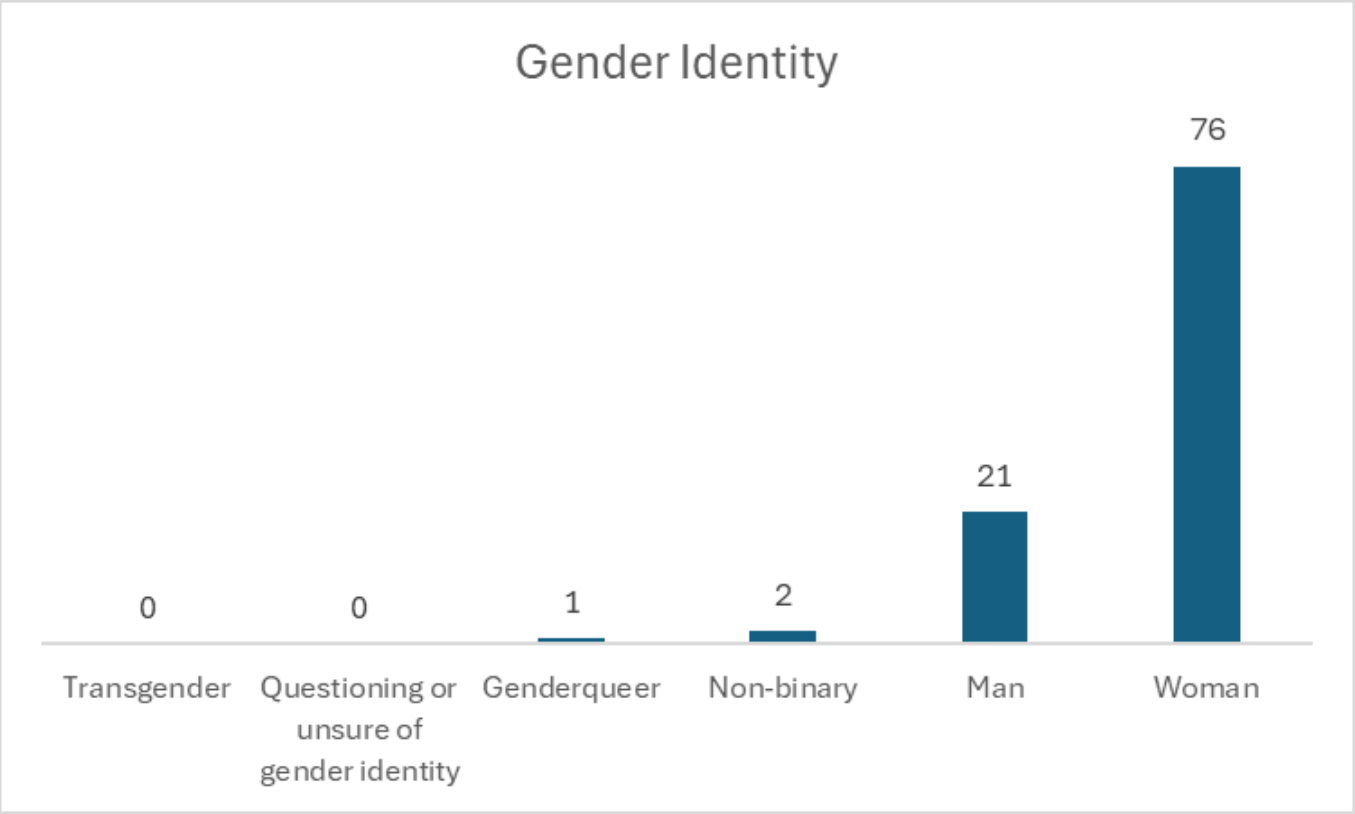

Age
0
8
68
28
0-15
16-25
26-59
60+

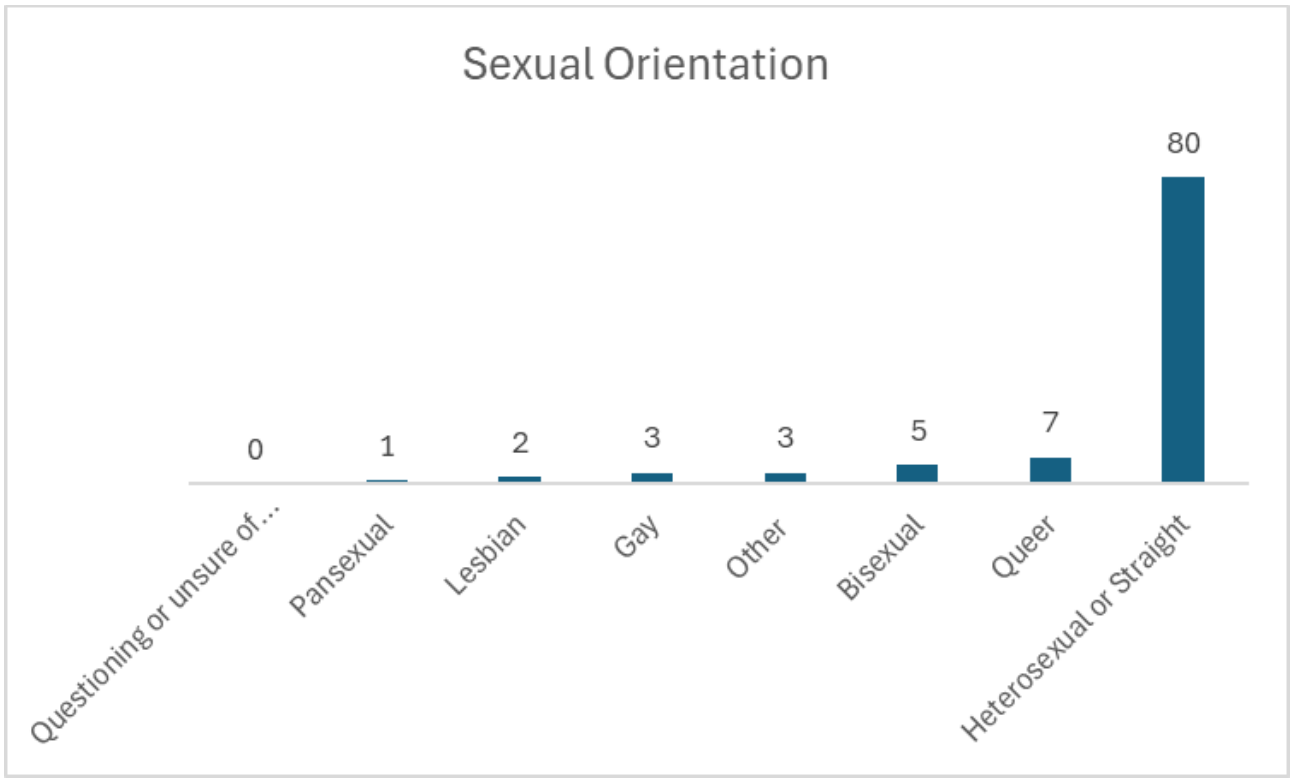

Race
1
2
2
5
7
8
55
Native Hawaiian or other Pacific Islander
American Indian or Alaska Native
Other
Black or African American
Asian
More than one race
White

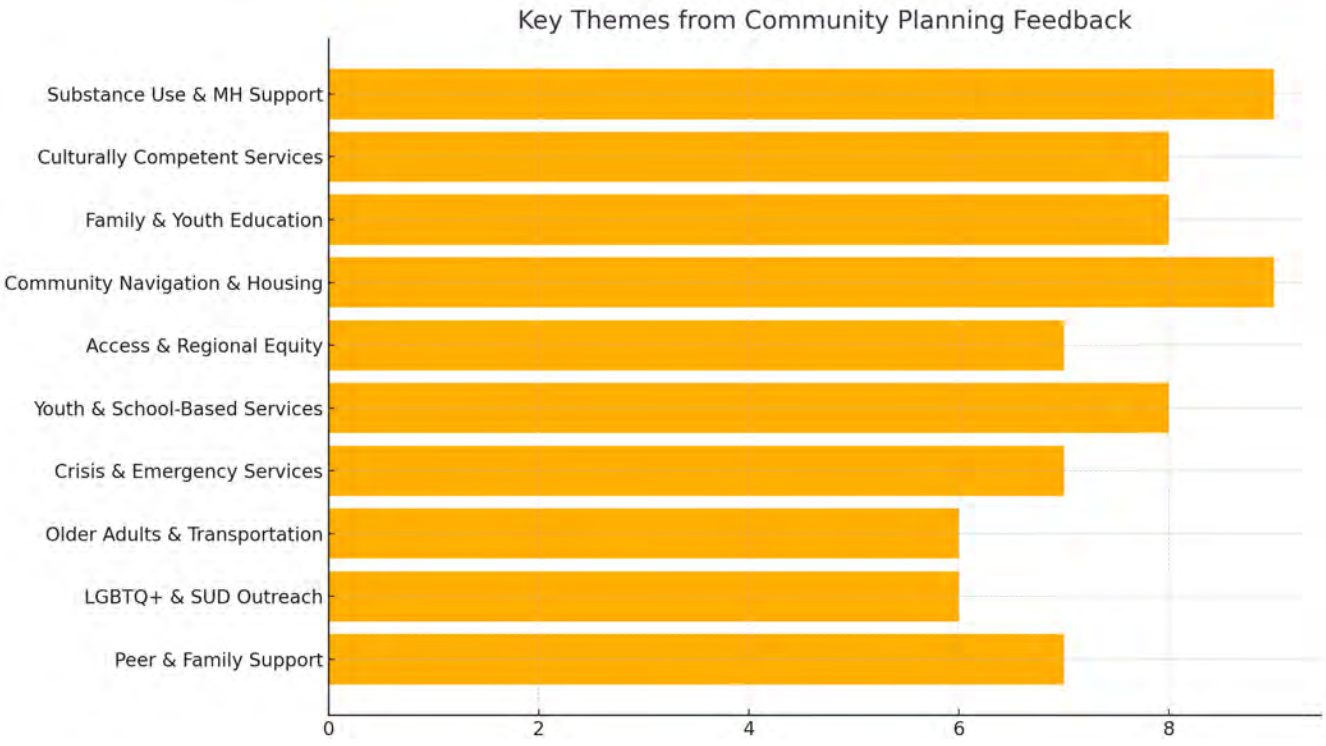

Latino Ethnicity
1
7
9
10
18
Puerto Rican
South American
Other Hispanic or Latino…
Central American
Mexican/Mexican-…


Other Ethnicity
1
1
2
2
2
3
4
6
24
African
Vietnamese
Chinese
Asian Indian/South Asian
Filipino
More than one ethnicity
Eastern European
Other non-Hispanic ethnicity
European


Language Spoken at Home
75
25
1
1
1
Cantonese
Other
Russian
Spanish
English


Gender Identity
76
21
0
0
1
2
Transgender
Questioning or unsure of gender identity
Genderqueer
Non-binary
Man
Woman

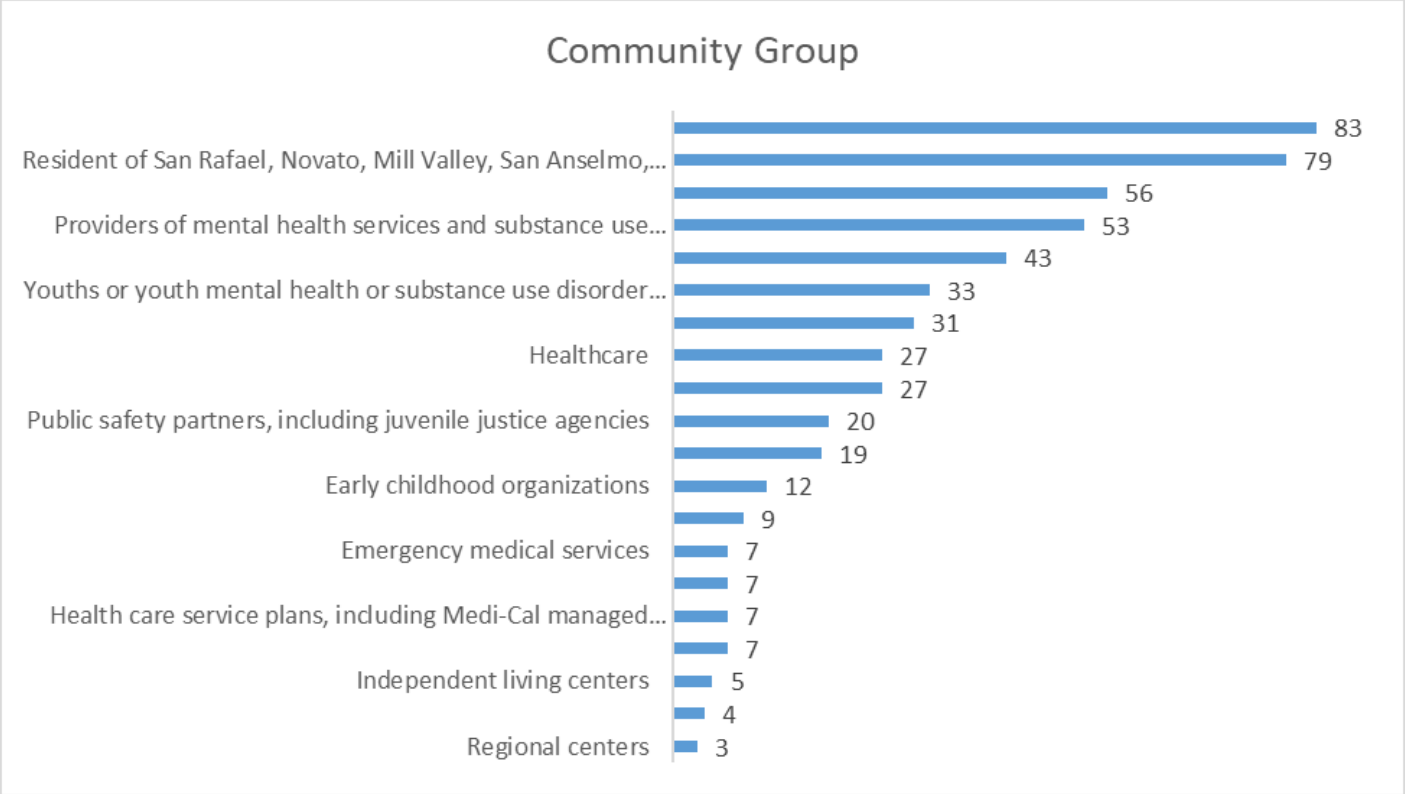

Sexual Orientation
0
1
2
3
3
5
7
80
Questioning or unsure of…
Pansexual
Lesbian
Gay
Other
Bisexual
Queer
Heterosexual or Straight

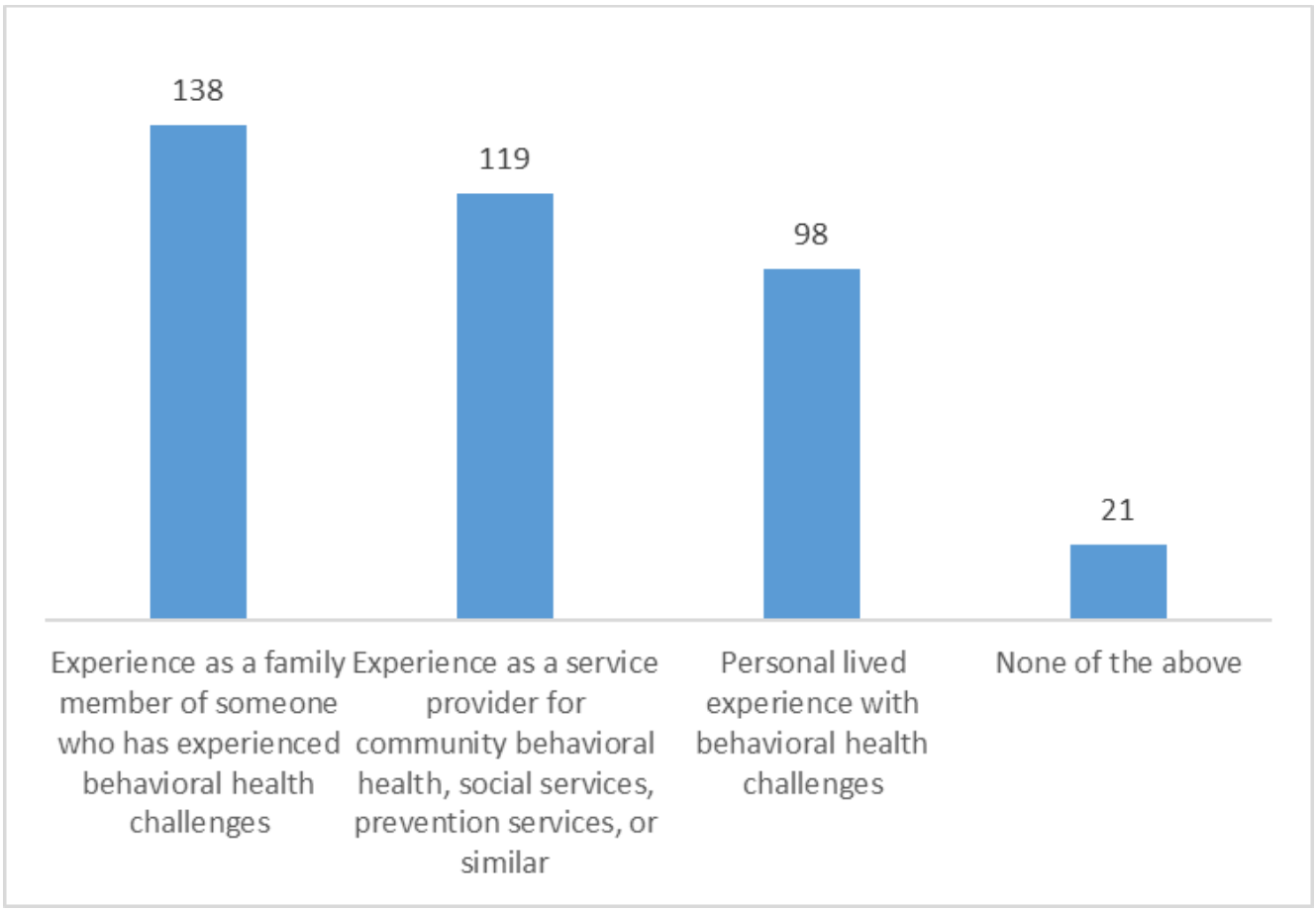

Key Themes from Community Planning Feedback
Substance Use & MH Support
Culturally Competent Services
Family & Youth Education
Community Navigation & Housing
Access & Regional Equity
Youth & School-Based Services
Crisis & Emergency Services
Older Adults & Transportation
LGBTQ+ & SUD Outreach
Peer & Family Support
0
2
4
6
8

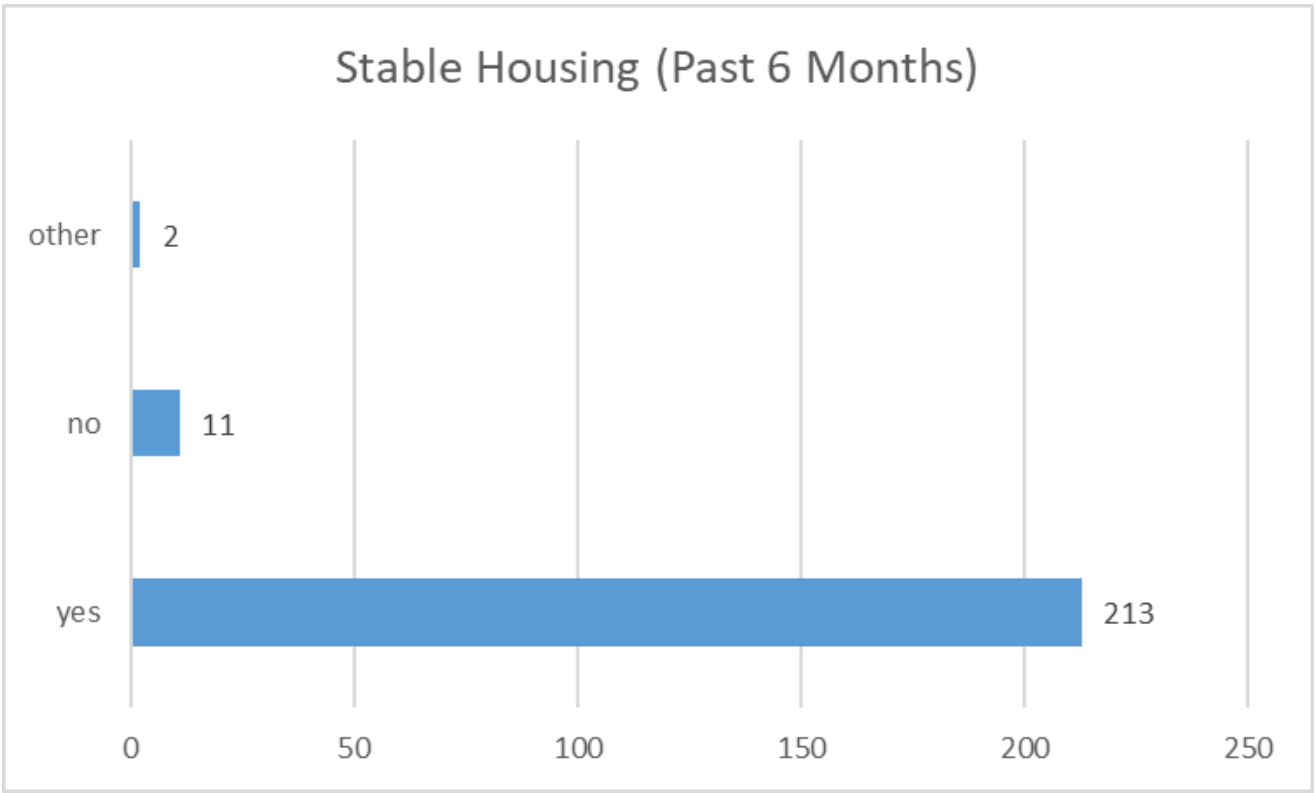
Behavioral Health Services Act (BHSA) FY26/27-FY28/29 Three-Year Integrated Plan Survey

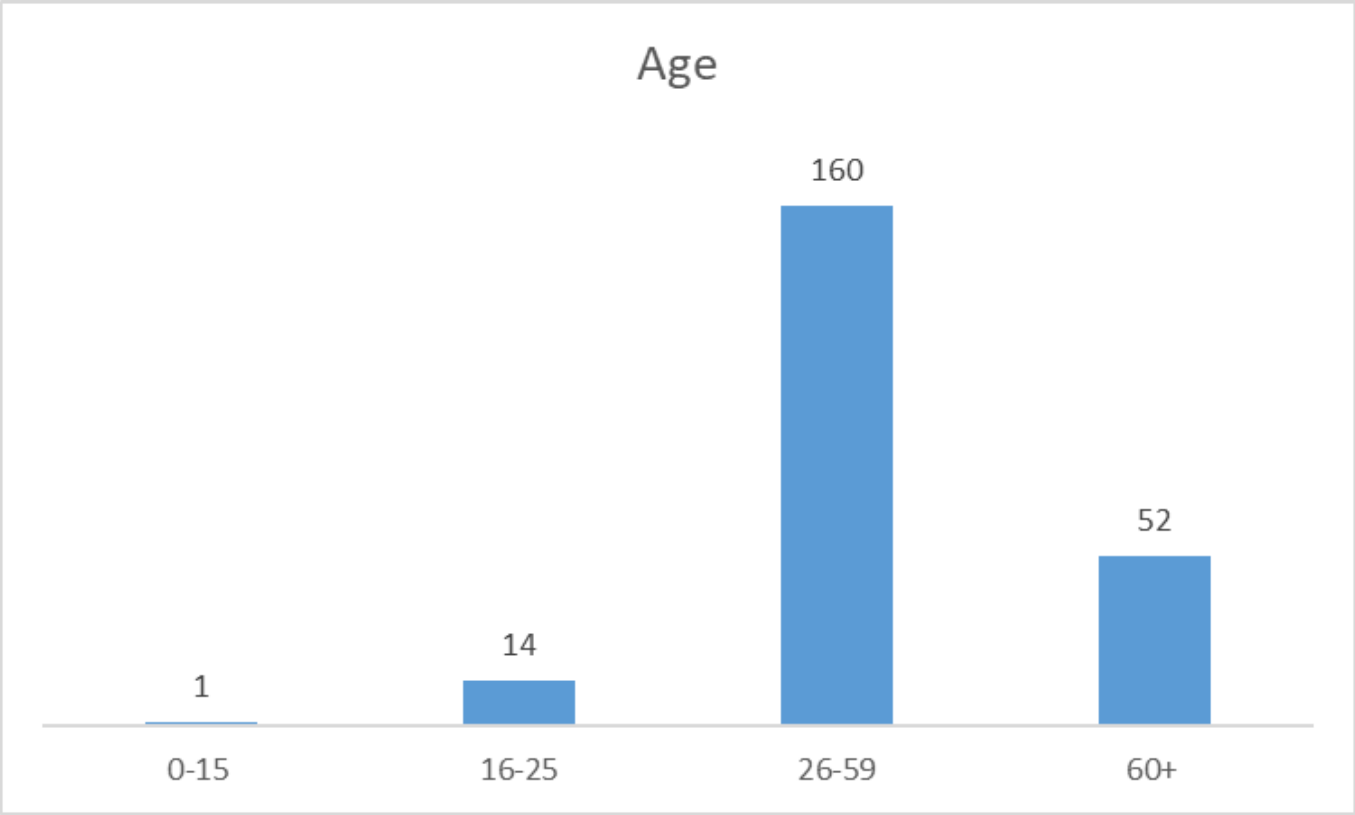
11/14/2024 – 5/21/2025, available in English, Spanish, and Vietnamese

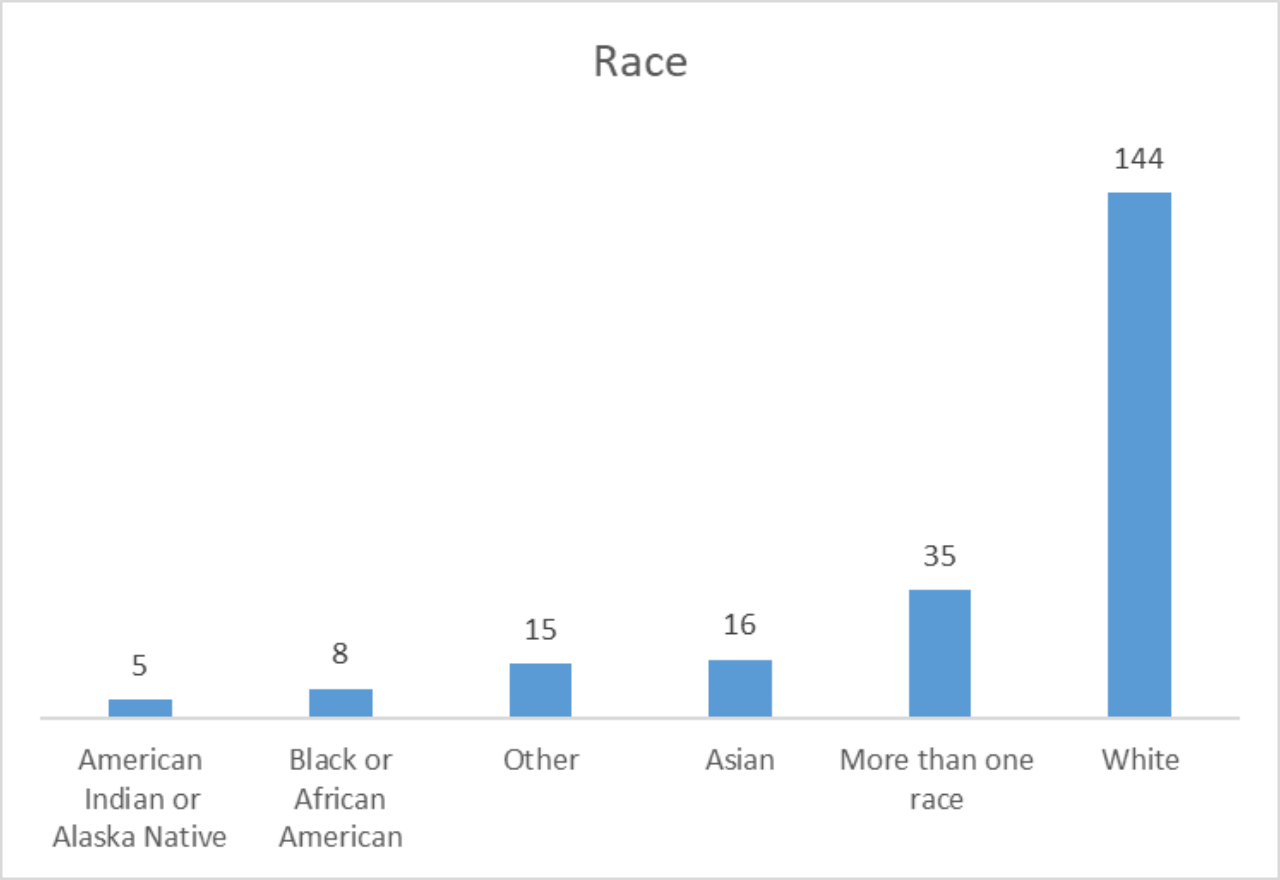
230 respondents

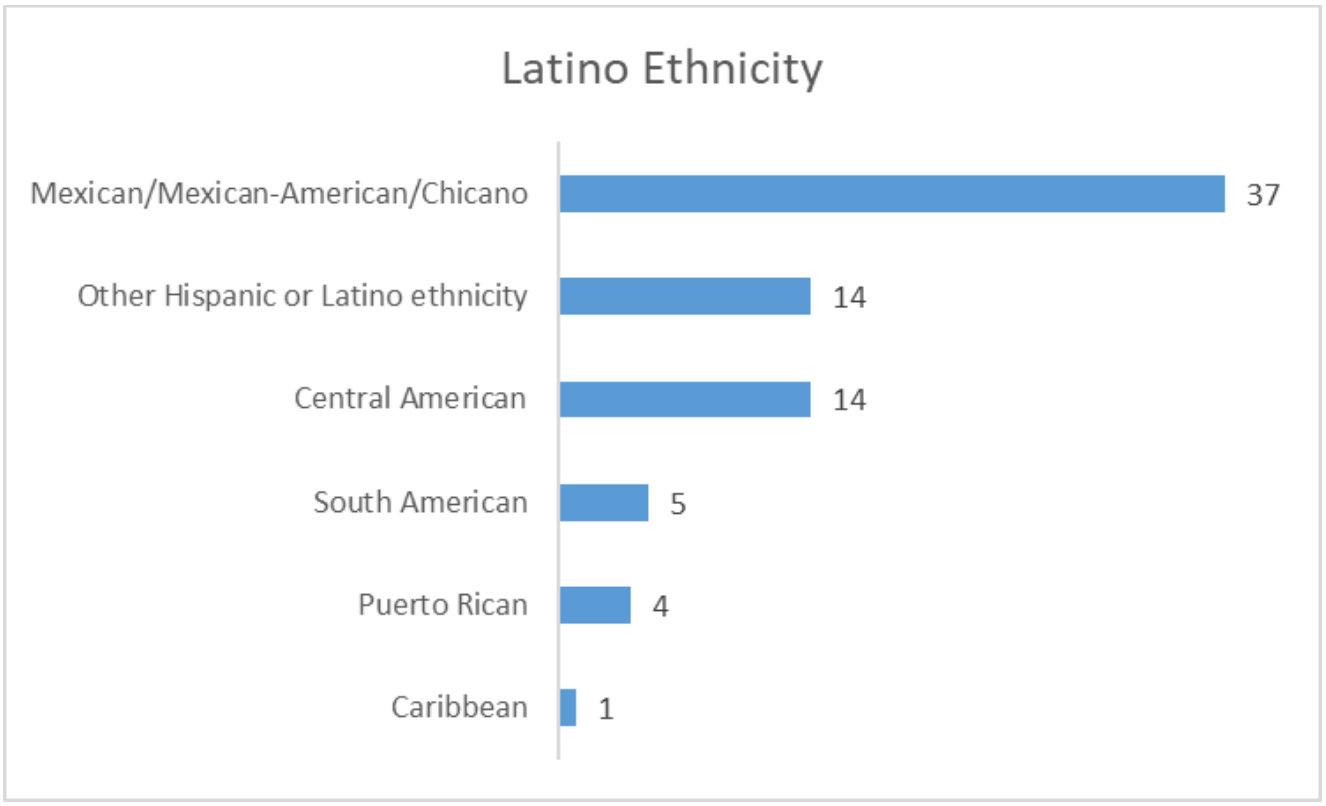


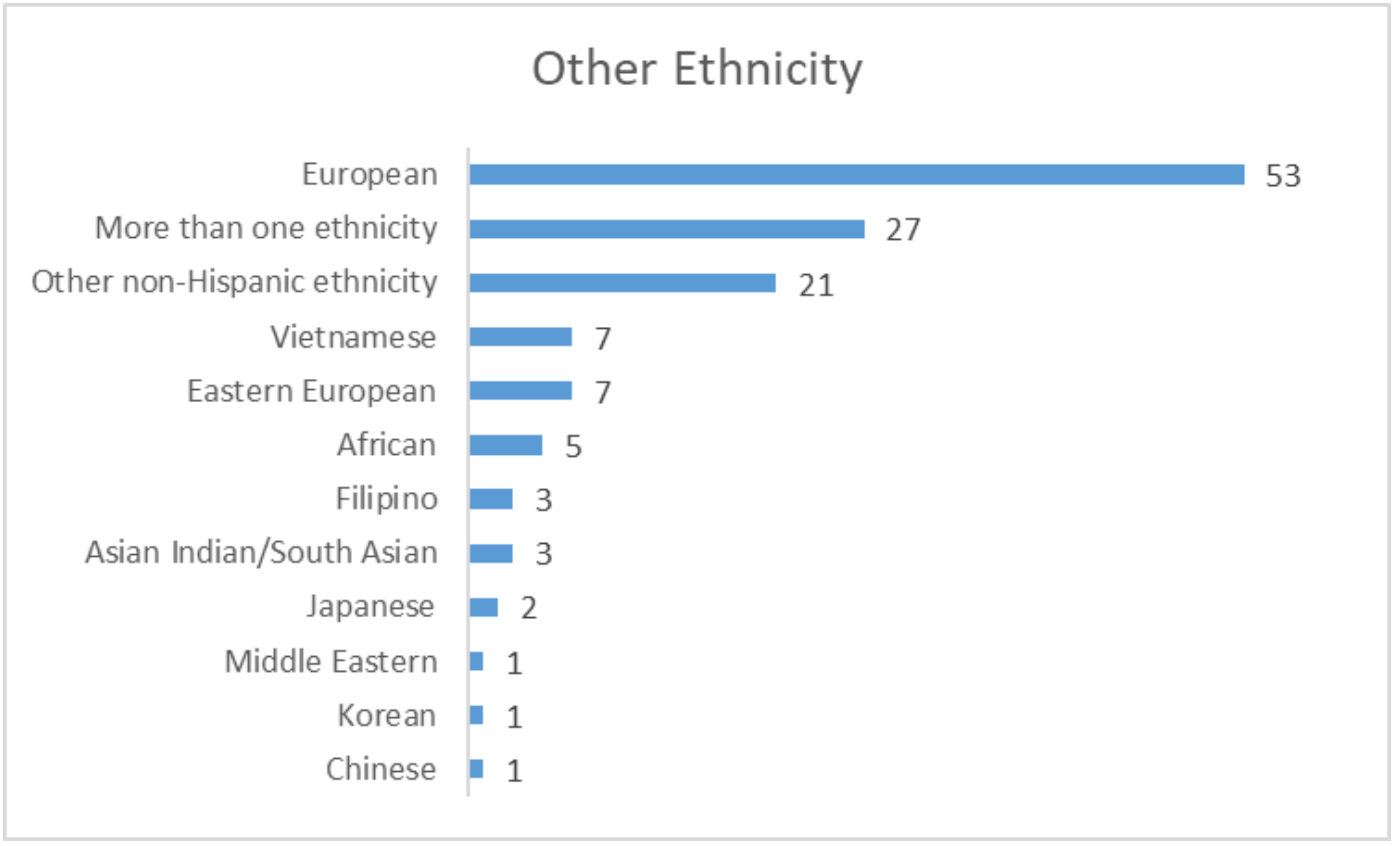

138
119
98
21
Experience as a family member of someone who has experienced behavioral health challenges
Experience as a service provider for community behavioral health, social services, prevention services, or similar
Personal lived experience with behavioral health challenges
None of the above

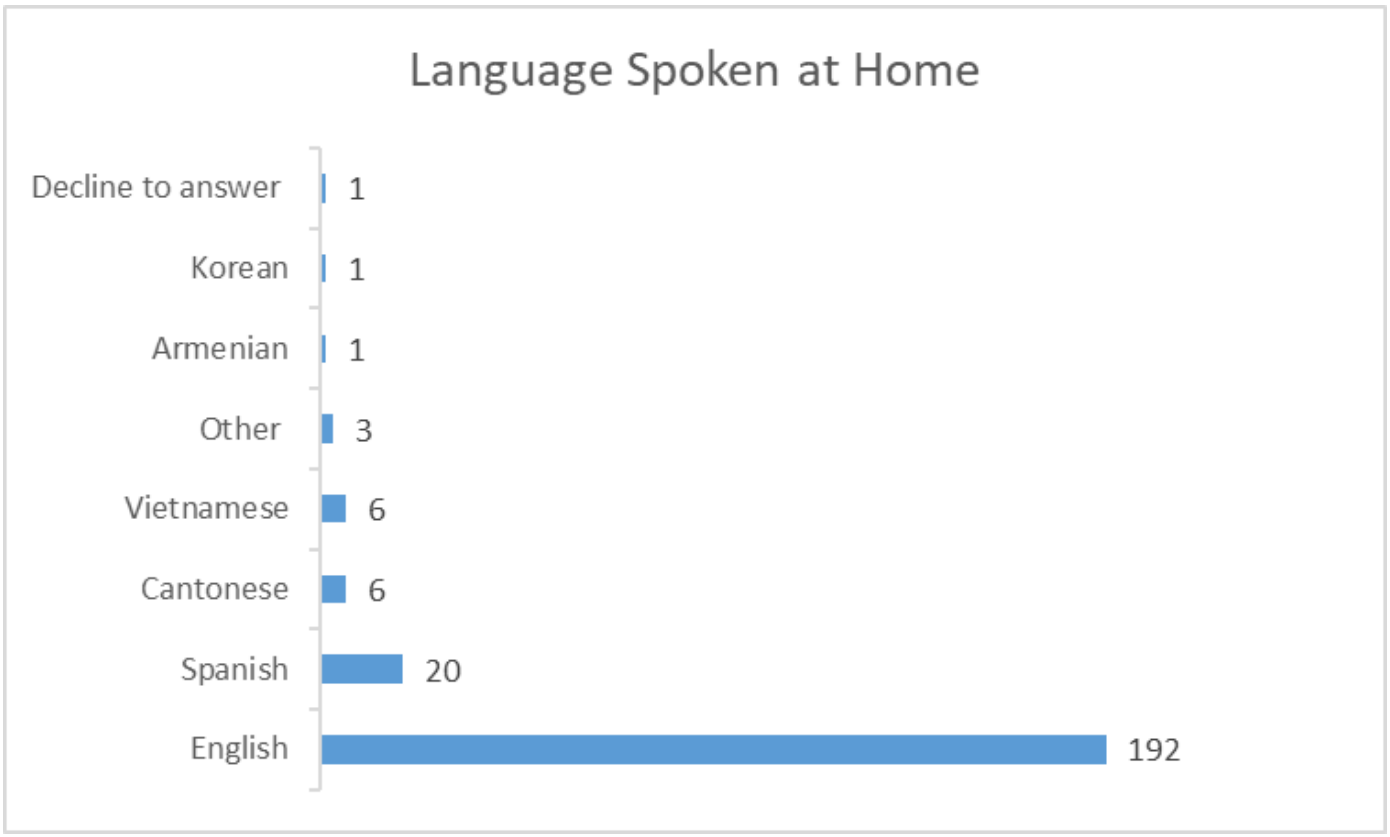

Stable Housing (Past 6 Months)
other
2
no
11
yes
213
0
50
100
150
200
250

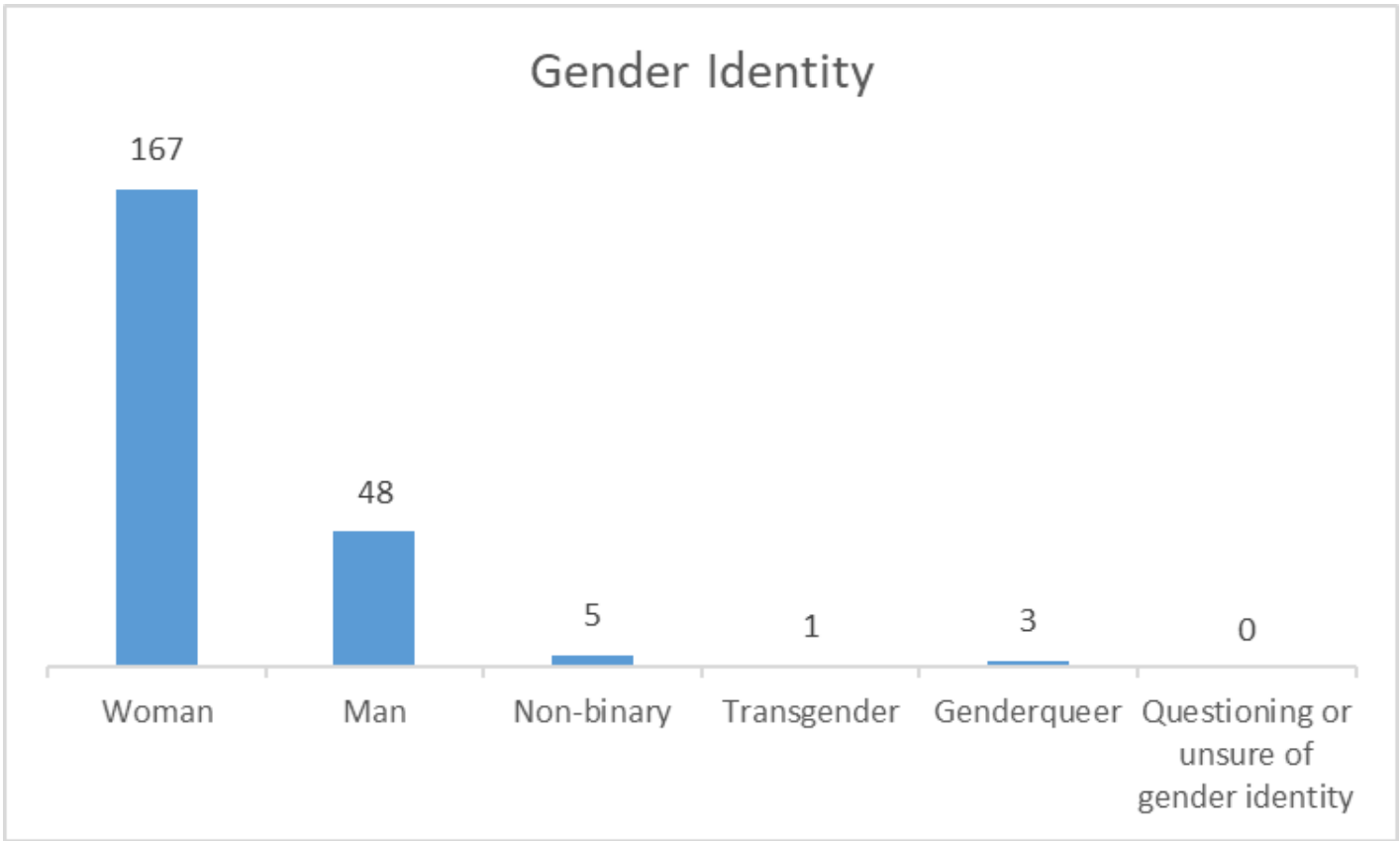

Age
160
52
14
1
0-15
16-25
26-59
60+

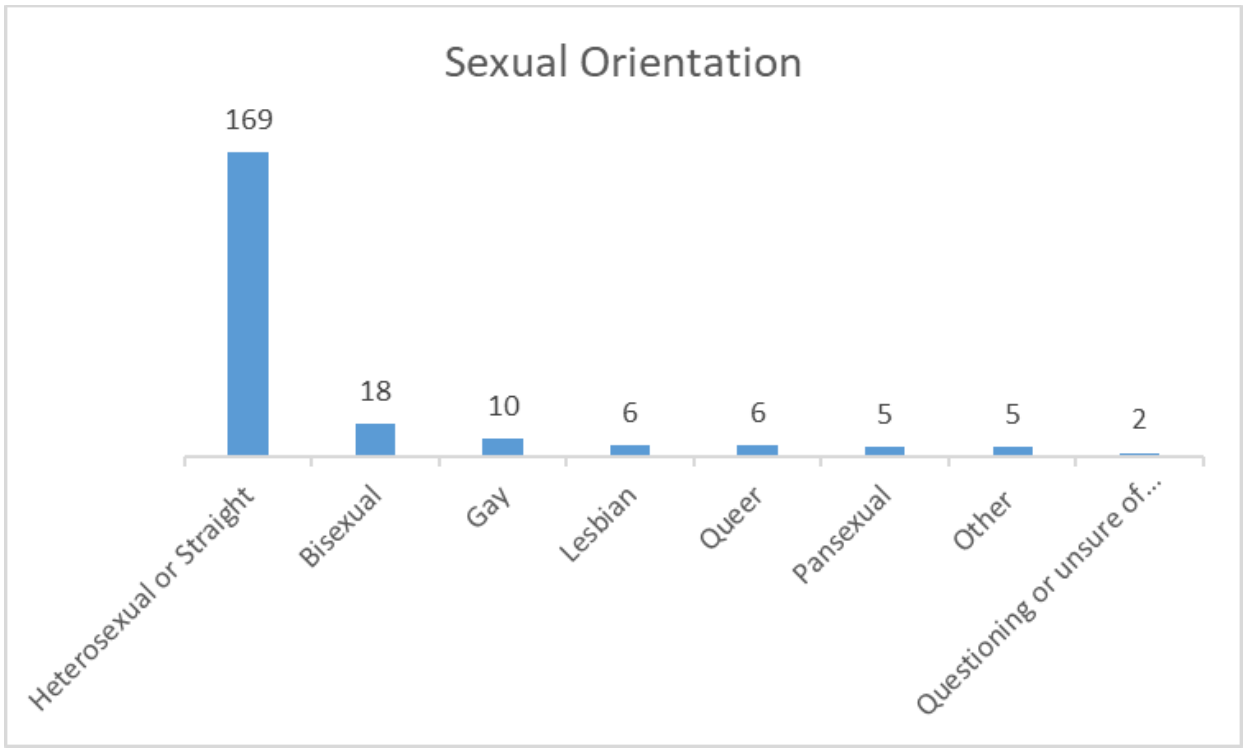

Race
144
35
15
16
8
5
American Indian or Alaska Native
Black or African American
Other
Asian
More than one race
White

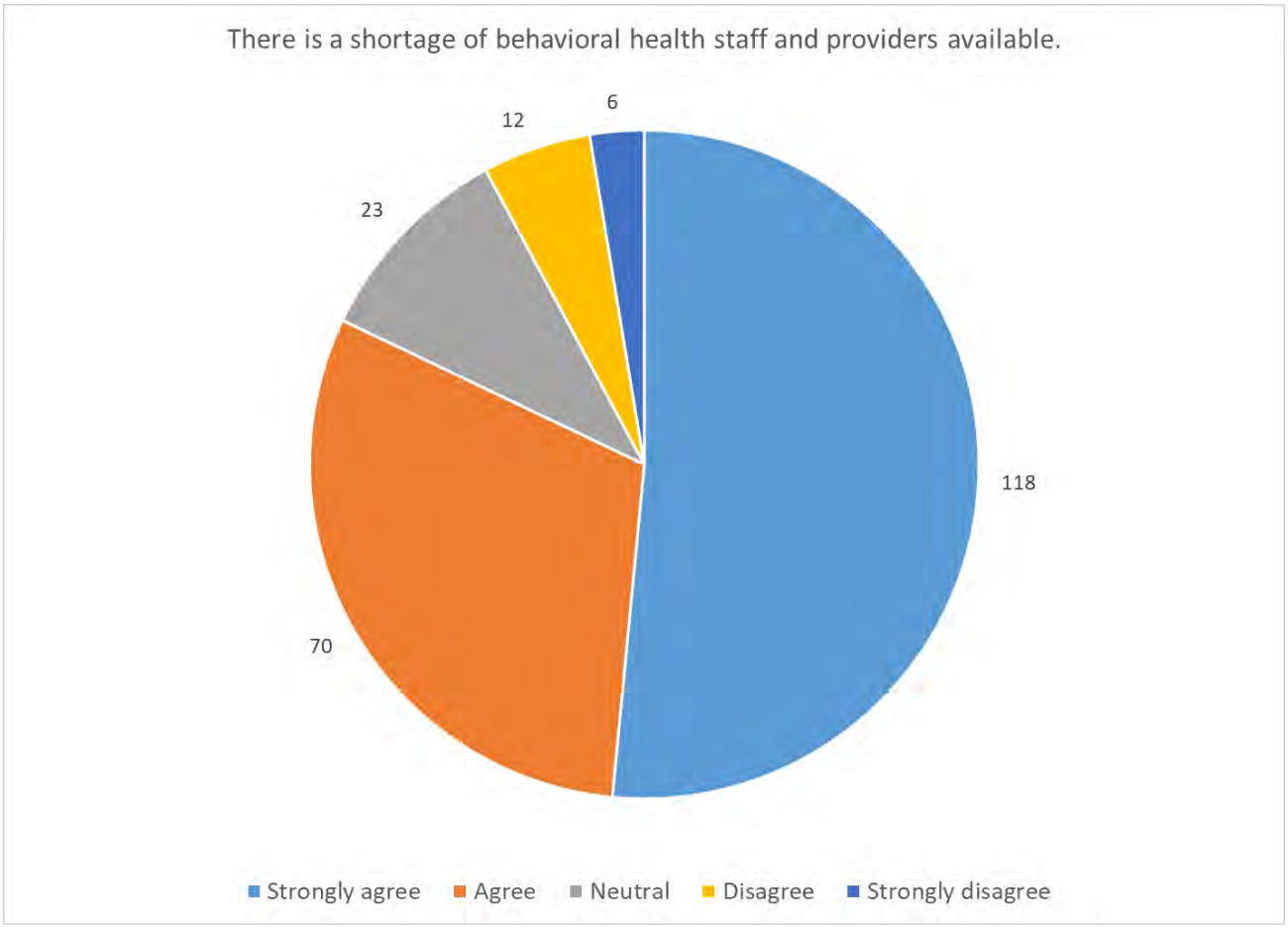

Latino Ethnicity
Mexican/Mexican-American/Chicano
37
Other Hispanic or Latino ethnicity
14
Central American
14
South American
5
Puerto Rican
4
Caribbean
1


Other Ethnicity
European
53
More than one ethnicity
27
Other non-Hispanic ethnicity
21
Vietnamese
7
Eastern European
7
African
5
Filipino
3
Asian Indian/South Asian
3
Japanese
2
Middle Eastern
1
Korean
1
Chinese
1


Language Spoken at Home
Decline to answer
1
Korean
1
Armenian
1
Other
3
Vietnamese
6
Cantonese
6
Spanish
20
English
192


Gender Identity
167
48
5
1
3
0
Woman
Man
Non-binary
Transgender
Genderqueer
Questioning or unsure of gender identity


Sexual Orientation
169
18
10
6
6
5
5
2
Heterosexual or Straight
Bisexual
Gay
Lesbian
Queer
Pansexual
Other
Questioning or unsure of...


There is a shortage of behavioral health staff and providers available.
6
12
23
118
70
Strongly agree
Agree
Neutral
Disagree
Strongly disagree

BHSA Survey Ranked Priorities

1. Addressing barriers to accessing behavioral health services, including rapid intake assessments and reduced wait-times to first appointment with service providers
2. Housing and supportive housing services for individuals with a serious behavioral health disorder
3. Substance use treatment for adults and older adults
4. Increasing the number of peer providers or expanding peer programs to support individuals and their families
5. Increasing the number of bilingual and bicultural behavioral health providers
6. Increasing services for justice involved individuals with a serious behavioral health
7. Substance use treatment for youth and TAY
8. Additional supports for field-based mobile crisis teams
9. Creating a regional hub model to serve residents (e.g., South Marin, Central Marin, etc.)
10. Implementation of evidence-based practices
11. Sober living environments for adults
12. Residential treatment options for youth, including substance use treatment

BHSA Early Intervention Ranked Priorities

1. Early intervention with youth (0 – 18 years old) to address behavioral health needs that may indicate behavioral health difficulties and increase timely access to treatment services
2. Early intervention with individuals experiencing a suicidal, mental health and/or substance use-related crisis (e.g., hotlines, mobile crisis services)
3. Responding to the behavioral health needs of historically underserved communities, including but not limited to Black and African American, Hispanic, Asian, and LGBTQ+ to address barriers when accessing behavioral health services
4. Early identification of behavioral health disorders across the lifespan
5. Responding to the behavioral health needs of older adults (65 and over)
6. Responding to the behavioral health needs of pregnant and of postpartum women with an infant in the first year of life

CLASSIFIEDS

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Ordinance No. 2357

NOTICE INVITING BIDS

Sealed bids for the **On-Call Roads and Trails Maintenance 2025 – 2028 Contract No. 2457** will be received at the Office of the Manager of Engineering, Marin Municipal Water District ("MMWD" or "District"), 220 Nellen Avenue, Corte Madera, CA 94925, until 11:00 a.m. on October 31, 2025, at which time they will be publicly opened and read in the Board of Directors' room by the Secretary or a designated representative. This contract is for furnishing labor and equipment to support the replacement of watershed culverts and for general maintenance of a portion of the watershed road and trails system which includes 100 miles of fire roads and 60 miles of hiking trails. The work to be done is located near the intersection of Bolinas-Fairfax Road and Sky Oaks Rd. in the Mt Tamalpais Watershed within the County of Marin, California.

The Contractor performing work under this contract shall possess one of the following licenses: **A- General Engineering Contractor, C-61 – California Contractors license-Limited Specialty, or C-12 Earthwork and Paving Contractor, which is valid in the State of California at the time the contract is awarded.**

No contractor or subcontractor may be listed on a bid proposal for a public works project (submitted on or after March 1, 2015) unless registered with the Department of Industrial Relations pursuant to Labor Code section 1725.5 with limited exceptions from this requirement for bid purposes only under Labor Code section 1771.1(a).

No contractor or subcontractor may be awarded a contract for public work on a public works project awarded on or after April 1, 2015 unless registered with the Department of Industrial Relations pursuant to Labor Code section 1725.5.

This project is subject to compliance monitoring and enforcement by the Department of Industrial Relations.

The prevailing rate of wages in the locality in which work is to be performed has been ascertained by the District and published under the provisions of Section 1773 of the California Labor Code. For the most current prevailing wage rates the Contractor may visit the state of California Prevailing Wage Determinations website at **http://www.dir.ca.gov/DLSR/PWD.**

Copies of the prevailing wage rates are also on file and available at the Office of the Manager of Engineering at 220 Nellen Avenue, Corte Madera, and in the office of the Marin County Department of Public Works, Civic Center, Room 304, San Rafael, California. It shall be mandatory upon the Contractor to whom the contract is awarded and upon any subcontractor under him to pay not less than the said prevailing wage rates to all workers employed by them in the execution of the contract.

On this contract, eight hours shall constitute a legal day's work. Work beyond eight hours shall be paid at a rate not less than one and one-half times the prevailing rates. Wage rates for Sundays and holidays shall be paid at a rate not less than two times the prevailing rates. The holidays upon which such rates shall be paid shall be all holidays recognized in the collective bargaining agreement applicable to the particular craft, classification or type of workers employed on the project.

No contractor may be awarded a contract for public work on a public works project unless they provide copies of valid Certificates of Reported Compliance issued by the California Air Resources Board (CARB), as described in California Code of Regulations, title 13, ("13 CCR") section 2449(h), for their fleet, and the fleets of any Heavy Duty Contractors, of all vehicles subject to 13 CCR section 2449 which may be use in performance of the contract.

Unless otherwise specified, proposals will be considered for the complete job only. In accordance with the instructions to Bidders, all bid documents must be completed on forms supplied with the contract specifications. Each Bidder is requested to return the entire specification booklet. The Bidder must include a certified check, cash, cashier's check or bid bond executed by an admitted surety authorized by the California State Department of Insurance to transact business in California as a guarantee that the Bidder will, if successful, promptly execute a satisfactory contract and furnish bonds as required by these specifications. The certified check, cash, cashier's check or bid bond shall be not less than ten (10) percent of the total amount of the bid and shall be payable to the Marin Municipal Water District.

In compliance with Section 22300 of the Public Contract Code, the Successful Bidder may, at his option, choose to exercise one of the following options regarding retentions: (1) to deposit securities under District control, equivalent to the retention amount normally withheld by the District; or (2) to execute an escrow agreement and have the District make retention payments directly to an escrow agent; or (3) to use a retention agreement indicating that normal retention will be deposited in a joint account under District control. If an escrow agreement for security deposits is used in lieu of retention, it shall be in a form substantially similar to that specified in Public Contracts Code Section 22300.

If any of the above options are chosen, the District will withhold no retention on progress payments. District control of securities in accounts will be released to the same manner as release of normal retention funds as indicated in the general specifications. Securities eligible for investment shall include those listed in Section 16430 of the Government Code or bank or savings and loan certificates of deposit.

The Bidder's attention is drawn to the General Specifications section regarding Dispute Resolution. This section provides any disputes or claims between the District and the Contractor are subject to mediation, and then if still unresolved, at the sole election of the District, to binding arbitration. The Bidder's attention is also called to Marin Municipal Water District Code Sections 2.60.065 through 2.60.067 which permit the District to disqualify a Contractor from bidding on future contracts with the District if the contractor fails to comply with the rules and regulations specified in the District's code or the requirements for performance specified in this contract including submission of false claims to the District.

BEFORE BIDDING: Bidders should contact their insurance brokers to verify that their insurance meets all insurance requirements of the contract and that their broker will provide a completed MMWD Additional Insured Endorsement. Bidders should provide pages XIV, XIV-a and XIV-b of the contract to their insurance brokers for reference.

Proposals must be submitted in a sealed envelope addressed to the attention of the Watershed Resources Manager, with the words **"On-Call Roads and Trails Maintenance 2025 – 2028 – CONTRACT NO.2457"** clearly marked on the outside of the envelope.

OBTAINING CONTRACT DOCUMENTS: Copies of the Contract documents, specifications, and drawings may be previewed & purchased by logging on to **http://www.marinvitesplans.com/**, or by calling **BPX Printing** at **510-559-8295.** These items may be obtained at a set price of **$25.00, plus shipping,** and is non-refundable. All bidders must purchase a complete bid set from the BPX Printing prior to bid opening in order to be considered responsive and to receive addenda notifications and provide a receipt with bid documents.

The District reserves the right to reject any and all bids and to waive any irregularities in said bids.

Terri Gillen

Board Secretary

Board of Directors

FICTITIOUS BUSINESS NAME STATEMENT
COUNTY OF MARIN
File No. 159790
Business or stage name(s) on: June 30, 2022
The following person(s) is (are) doing business as:
Gino's Lotto
156 Anderson Drive San Rafael, CA 94901
LJ Lotto Albert Park LLC
156 Anderson Drive San Rafael, CA 94901
County of principal place of business: Marin County
This business is conducted by: A LIMITED LIABILITY COMPANY
/s/ Lotto Albert Park LLC
FILED: October 9, 2025
SHELLY SCOTT
MARIN COUNTY CLERK
By: J Meenan, Deputy
NOTICE: This statement expires on October 10, 2030. A new FBN statement must be filed on or after that date.
The filing does not of itself authorize the use of the name in violation of the rights of another under federal, state or common law. (B&P Code 14400 et seq.)
(MIJ#21387 September 22, 29, October 6, 13, 2025)

Legal Notice | Legal Notice

A.P.N.: 165-760-01 Trustee Sale No.: 2025-1572 Title Order No.: 250237CAD NOTICE OF TRUSTEE'S SALE YOU ARE IN DEFAULT UNDER A DEED OF TRUST DATED 3/3/2006. UNLESS YOU TAKE ACTION TO PROTECT YOUR PROPERTY, IT MAY BE SOLD AT A PUBLIC SALE. IF YOU NEED AN EXPLANATION OF THE NATURE OF THE PROCEEDING AGAINST YOU, YOU SHOULD CONTACT A LAWYER. A public auction sale to the highest bidder for cash, cashier's check drawn on a state or national bank, check drawn by a state or federal credit union, or a check drawn by a state or federal savings and loan association, or savings association, or savings bank specified in Section 5102 of the Financial Code and authorized to do business in this state will be held by the duly appointed trustee as shown below, of all right, title, and interest conveyed to and now held by the trustee in the hereinafter described property under and pursuant to a Deed of Trust described below. The sale will be made, but without covenant or warranty, expressed or implied, regarding title, possession, or encumbrances, to pay the remaining principal sum of the note(s) secured by the Deed of Trust, with interest and late charges thereon, as provided in the note(s), advances, under the terms of the Deed of Trust, interest thereon, fees, charges and expenses of the Trustee for the total amount (at the time of the initial publication of the Notice of Sale) reasonably estimated to be set forth below. The amount may be greater on the day of sale. Trustor: ELENA KEATING, AN UNMARRIED WOMAN
Duly Appointed Trustee: S.B.S. TRUST DEED NETWORK, A CALIFORNIA CORPORATION
Recorded 3/7/2006 as Instrument No. 2006-0014791 in book NA, page NA of Official Records in the office of the Recorder of Marin County, California, Date of Sale: 10/30/2025 at 9:30 AM Place of Sale: OUTSIDE AT THE SOUTHWEST CORNER OF SAN RAFAEL CITY HALL, 1400 FIFTH AVENUE, SAN RAFAEL, CALIFORNIA 94901 Amount of unpaid balance and other charges: $695,207.26 Street Address or other common designation of real property: 100 IGNACIO VALLEY CIRCLE NOVATO, CALIFORNIA 94949 A.P.N.: 165-760-01 The undersigned Trustee disclaims any liability for any incorrectness of the street address or other common designation, if any, shown above. If no street address or other common designation is shown, directions to the location of the property may be obtained by sending a written request to the beneficiary within 10 days of the date of first publication of this Notice of Sale. NOTICE TO POTENTIAL BIDDERS: If you are considering bidding on this property lien, you should understand that there are risks involved in bidding at a trustee auction. You will be bidding on a lien, not on the property itself. Placing the highest bid at a trustee auction does not automatically entitle you to free and clear ownership of the property. You should also be aware that the lien being auctioned off may be a junior lien. If you are the highest bidder at the auction, you are or may be responsible for paying off all liens senior to the lien being auctioned off, before you can receive clear title to the property. You are encouraged to investigate the existence, priority, and size of outstanding liens that may exist on this property by contacting the county recorder's office or a title insurance company, either of which may charge you a fee for this information. If you consult either of these resources, you should be aware that the same lender may hold more than one mortgage or deed of trust on the property.
NOTICE TO PROPERTY OWNER: The sale date shown on this notice of sale may be postponed one or more times by the mortgagee, beneficiary, trustee, or a court, pursuant to Section 2924g of the California Civil Code. The law requires that information about trustee sale postponements be made available to you and to the public, as a courtesy to those not present at the sale. If you wish to learn whether your sale date has been postponed, and, if applicable, the rescheduled time and date for the sale of this property, you may call (855) 980-9340 or visit this internet Website www.superiordefault.com, using the file number assigned to this case 2025-1572. Information about postponements that are very short in duration or that occur close in time to the scheduled sale may not immediately be reflected in the telephone information or on the Internet Website. The best way to verify postponement information is to attend the scheduled sale. For sales conducted after January 1, 2021: NOTICE TO TENANT: You may have a right to purchase this property after the trustee auction pursuant to Section 2924m of the California Civil Code. If you are an "eligible tenant buyer," you can purchase the property if you match the last and highest bid placed at the trustee auction. If you are an "eligible bidder," you may be able to purchase the property if you exceed the last and highest bid placed at the trustee auction. There are three steps to exercising this right of purchase. First, 48 hours after the date of the trustee sale, you can call (855) 980-9340, or visit the internet website www.superiordefault.com, using the file number assigned to this case 2025-1572 to find the date on which the trustee's sale was held, the amount of the last and highest bid, and the address of the trustee. Second, you must send a written notice of intent to place a bid so that the trustee receives it no more than 15 days after the trustee's sale. Third, you must submit a bid so that the trustee receives it no more than 45 days after the trustee's sale. If you think you may qualify as an "eligible tenant buyer" or "eligible bidder," you should consider contacting an attorney or appropriate real estate professional immediately for advice regarding this potential right to purchase. Date: 9/22/2025 S.B.S. TRUST DEED NETWORK, A CALIFORNIA CORPORATION 31194 La Baya Drive, Suite 106 Westlake Village, California, 91362 Sale Line: (855) 980-9340 Phone Number 818-237-0108 By: Colleen Irby, Trustee Sale Officer (TS# 2025-1572 SDI-15251)

NOTICE OF LIEN SALE
SELF STORAGE AUCTION

NOTICE IS HEREBY GIVEN that the undersigned intends to sell the items property described below, pursuant to the provisions of the California Code of Civil Procedure and the provisions of the California Self-Storage Facilities Act, Business and Professions Code, Sections 21700 et seq.

On October 23, 2025 at 2:30 pm, the undersigned will sell the contents of items storage unit by public sale by competitive bidding on the premises where said property has been stored and which are located at Mill Valley Stor-All, 799 Redwood Hwy, Mill Valley, California. Self-storage items/ units generally include miscellaneous household goods, office or business equipment, misc. furniture, furnishings, clothing and personal effects belonging to:

Claudette Gregg

Purchases must be paid for at the time of purchase with cash only. All purchased items sold as-is, where-is, and must be removed at the time of sale. Sale subject to cancelation in the event of settlement between owner and obligated party. Call ahead to make sure sale is still scheduled. Contraband or items subject to regulation or registration will not be tendered with the items and unless otherwise noted.

John Cardozo CAL Bond #8266865
415-383-7735

The Behavioral Health Services Act Integrated Plan FY26/27 - FY28/29 is now available for a 30-day public comment period from October 3 – November 4, 2025. The BHSA was passed in 2024 and is driven by community members and individuals with lived experience.
You can read the FY26/27 – FY28/29 BHSA Integrated Plan at: MarinBHRS.org/BHSA
Please add any comments at: https://forms.office.com/g/CCcSyJMG1T
The FY26/27 – FY28/29 BHSA Integrated Plan includes: Full-Service Partnership programs, Behavioral Health Services and Supports, Early Intervention programs and Housing interventions. At this and (This 3-day) period, the Behavioral Health Board will host a Public Hearing. The public is welcome to attend. The Public Hearing will be held at 6pm on Tuesday, November 4, 2025 at 20 North San Pedro Rd. San Rafael, CA in the Post Royal Conference Room.
Please reach out to BHRSWIB@marincounty.gov with questions or accessibility needs.
IMIJ#65227 October 13, 2025

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MARIN BEHAVIORAL HEALTH & RECOVERY SERVICES

MARIN HEALTH & HUMAN SERVICES

LEAD WITH YOUR VOICE

Marin County's BHSA Integrated Plan FY26/27–FY28/29 is now open for public comment!

Public Hearing
Nov 04 @ 6pm



Read the plan and submit your comment at
prevention.marinbhrs.org/MHSA

MARIN BEHAVIORAL HEALTH & RECOVERY SERVICES

MARIN HEALTH & HUMAN SERVICES

HAVE A SAY IN MARIN'S MENTAL HEALTH FUTURE

Marin County's BHSA Integrated Plan FY26/27–FY28/29 is now open for public comment!

Public Hearing
Nov 04 @ 6pm



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MARIN BEHAVIORAL HEALTH & RECOVERY SERVICES

MARIN HEALTH & HUMAN SERVICES

HOUSING. HEALING. HOPE.
INSIDE THE PLAN

Marin County's BHSA Integrated Plan FY26/27–FY28/29 is now open for public comment!

Public Hearing
Nov 04 @ 6pm



Read the plan and submit your comment at
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MARIN BEHAVIORAL HEALTH & RECOVERY SERVICES

MARIN HEALTH & HUMAN SERVICES

LAST DAY TO SHARE YOUR VOICE

Marin County's BHSA Integrated Plan FY26/27–FY28/29 is now open for public comment!

Public Hearing
Nov 04 @ 6pm



Read the plan and submit your comment at
prevention.marinbhrs.org/MHSA

BEHAVIORAL HEALTH SERVICES ACT (BHSA) INTEGRATED PLAN FY26/27 – FY28/29 RELEASED FOR PUBLIC COMMENT

The BHSA Integrated Plan FY26/27 - FY28/29 is now posted for a 30-day public comment period from October 3 to November 4, 2025

You can read the draft BHSA Integrated Plan FY26/27 – FY28/29 here

Please add your comment here

What's included:

- **Housing Interventions**, including permanent supportive housing, peer respite, and rental subsidies
- **Full-Service Partnership programs**, including Assertive Field-Based SUD, Assertive Community Treatment, Intensive Case Management, Individual Placement and Support, and High Fidelity Wraparound programs
- **Behavioral Health Services and Supports**, including crisis stabilization, peer-driven recovery supports, and outreach that ensures timely access to behavioral health services
- **Early Intervention programs** for youth, adults, older adults, veterans, and underserved communities

At the end of this 30-day period, the Behavioral Health Board will host a Public Hearing. The public is welcome to attend. The Public Hearing will be held at 6pm on Tuesday November 4, 2025, at 20 North San Pedro Rd., San Rafael, CA in the Point Reyes Conference Room. Individuals may also attend virtually at via Zoom .

Meeting ID: 892 8195 5591
Passcode: 813893

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	☑	$ 143,321.00	$ 149,053.00	$ 155,016.00	$ 322,472.00	$ 335,371.00	$ 348,786.00	800.00	1800.00
Early Intervention Services	☑	$ 223,117.00	$ 232,041.00	$ 241,323.00	$ 7,829.00	$ 8,144.00	$ 8,467.00	68	2.00
Outpatient Services	☑	$ 4,308,185.00	$ 4,480,512.00	$ 4,659,733.00	$ 276,022.00	$ 287,063.00	$ 298,545.00	487	32.00
Intensive Outpatient Services	☑	$ 1,784,010.00	$ 1,855,370.00	$ 1,929,585.00	$ 27,066.00	$ 28,149.00	$ 29,275.00	216	4.00
Crisis and Field-Based Services	☑	$ 167,681.00	$ 174,388.00	$ 181,364.00	$ 5,884.00	$ 6,119.00	$ 6,364.00	68	2.00
Residential Treatment Services	☑	$ 7,431,132.00	$ 7,728,377.00	$ 8,037,513.00	$ 196,751.00	$ 204,621.00	$ 212,806.00	491	13.00
Inpatient Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	0	0.00
Mental Health (MH) Services									
Primary Prevention Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	0	0
Early Intervention Services	☑	$ 2,960,849.00	$ 3,003,459.00	$ 2,360,148.00	$ 2,608,944.00	$ 2,585,310.00	$ 2,572,270.00	7251	1638
Outpatient and Intensive Outpatient Services	☑	$ 23,394,758.00	$ 23,911,843.00	$ 24,933,346.00	$ 11,124,179.00	$ 12,169,146.00	$ 12,031,912.00	1867	563
Crisis Services	☑	$ 7,683,144.00	$ 7,740,470.00	$ 7,910,089.00	$ 1,355,849.00	$ 1,410,083.00	$ 1,366,486.00	1208	357
Residential Treatment Services	☑	$ 1,929,026.00	$ 2,006,187.00	$ 2,086,435.00	$ 250,000.00	$ 260,000.00	$ 270,400.00	34	8
Hospital and Acute Services	☑	$ 4,100,360.00	$ 4,234,375.00	$ 4,334,950.00	$ 446,771.00	$ 464,642.00	$ 483,227.00	220	28
Subacute and Long-Term Care Services	☑	$ 5,168,163.00	$ 5,374,890.00	$ 5,449,885.00	$ -	$ -	$ -	102	2
Housing Services (MH + SUD)									
Housing Services	☑	$ 14,368,152.00	$ 13,353,222.00	$ 13,619,533.00	$ 117,000.00	$ 121,680.00	$ 126,547.00	713	18
Total Projected Expenditures and Individuals Served									
Total Projected Expenditures and Individuals Served (auto-populated)		$ 73,661,898.00	$ 74,244,187.00	$ 75,898,920.00	$ 16,738,767.00	$ 17,880,328.00	$ 17,755,085.00	13525	4467

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	$ 2,246,128.00	$ 909,707.00	$ 936,998.00
Workforce Investment Activities	$ 345,162.00	$ 345,162.00	$ 345,162.00
Quality & Accountability, Data Analytics, and Plan Management & Administrative Activities (including indirect administrative activities)	$ 15,519,528.00	$ 16,140,309.00	$ 16,785,921.00
Other County Behavioral Health Agency Services/Activities (e.g., Public Guardian, CARE Act, LPS Conservatorships, DSH for Housing, Court Diversion Programs)	$ -	$ -	$ -
Total Projected Expenditures			
Total Projected Expenditures (auto-populated)	$ 18,110,818.00	$ 17,395,178.00	$ 18,068,081.00

Instructions

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

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

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

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

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

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

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

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

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

Table Three: Projected Annual Expenditures by County BH Funding Source			
	Total Annual Projected Expenditures (Year One)	**Total Annual Projected Expenditures (Year Two)**	**Total Annual Projected Expenditures (Year Three)**
BHSA	$ 23,004,142.00	$ 23,545,906.00	$ 22,263,900.00
1991 Realignment (Bronzan-McCorquodale Act)	$ 15,531,216.00	$ 15,531,216.00	$ 15,531,216.00
2011 Realignment (Public Safety Realignment)	$ 16,471,288.00	$ 16,738,265.00	$ 17,893,297.00
State General Fund	$ 2,692,283.00	$ 3,431,935.00	$ 3,854,719.00
FFP (SMHS, DMC/DMC-ODS, NSMHS)	$ 23,871,685.00	$ 23,124,325.00	$ 24,478,210.00
Projects for Assistance in Transition from Homelessness (PATH)	$ -	$ -	$ -
Community Mental Health Block Grant (MHBG)	$ 781,284.00	$ 781,284.00	$ 781,284.00
Substance Use Block Grant (SUBG)	$ 1,506,819.00	$ 1,506,819.00	$ 1,506,819.00
Commercial Insurance	$ 143,537.00	$ 350,714.00	$ 558,250.00
County General Fund	$ 21,004,736.00	$ 21,004,736.00	$ 21,349,898.00
Opioid Settlement Funds	$ 1,110,000.00	$ 1,535,000.00	$ 1,535,000.00
Other Funding Sources	**Total Annual Projected Expenditures (Year One)**	**Total Annual Projected Expenditures (Year Two)**	**Total Annual Projected Expenditures (Year Three)**
Other federal grants	$ -	$ -	$ -
Other state funding (including DSH funding)	$ 2,394,493.00	$ 1,969,493.00	$ 1,969,493.00
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)	$ 108,511,483.00	$ 109,519,693.00	$ 111,722,086.00
Total Projected Expenditure Variance	$ -	$ -	$ -
Auto-validation: Table 1: Behavioral Health Care Continuum Projected Expenditures	$ 90,400,665.00	$ 92,124,515.00	$ 93,654,005.00
Auto-validation: Table 2: Other County Expenditures	$ 18,110,818.00	$ 17,395,178.00	$ 18,068,081.00

Instructions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table Four: BHSA Transfers

	County Base BHSA Funding Allocations Housing Intervention	County Base BHSA Funding Allocations Full-Service Partnership	County Base BHSA Funding Allocations Behavioral Health Services and Support	County Base BHSA Funding Allocations Total
Year One Component Allocation (dollars)	$ 5,854,517.00	$ 6,830,270.00	$ 6,830,270.00	$ 19,515,057.00
Year Two Component Allocation (dollars)	$ 5,733,901.00	$ 6,689,551.00	$ 6,689,551.00	$ 19,113,003.00
Year Three Component Allocation (dollars)	$ 5,695,539.00	$ 6,644,796.00	$ 6,644,796.00	$ 18,985,131.00

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)	$ 5,854,517.00	$ 6,830,270.00	$ 6,830,270.00	$ 19,515,057.00
Unspent Mental Health Services Act (MHSA) to BHSA	$ 125,000.00	$ 2,674,000.00	$ 13,545,000.00	$ 16,344,000.00
Excess Prudent Reserve (PR) to BHSA	$ -	$ -	$ -	$ -

BHSA Transfers
Year Two Summary (auto-populated)

	Housing Intervention	Full-Service Partnership	Behavioral Health Services and Support	Totals
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	35%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 5,733,901.00	$ 6,689,551.00	$ 6,689,551.00	$ 19,113,003.00

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)	$ 5,695,539.00	$ 6,644,796.00	$ 6,644,796.00	$ 18,985,131.00

Funding Transfer Request Allocations

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption
(Ability to change component's overall percentage) (Year One)

Base Component (Year One)	Housing Intervention Percentage (Year One)	Housing Intervention Funds (Year One)
Base Percentage and Funding	30%	$ 5,854,517.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 5,854,517.00
Transferred To/From	**Full Service Partnership Percentage (Year One)**	**Full Service Partnership Funds (Year One)**
Base Percentage and Funding	35%	$ 6,830,270.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 6,830,270.00
Transferred To/From	**Behavioral Health Services and Support Percentage (Year One)**	**Behavioral Health Services and Support Funding (Year One)**
Base Percentage and Funding	35%	$ 6,830,270.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 6,830,270.00

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 (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year Two)		
Base Component (Year Two)	**Housing Intervention Percentage (Year Two)**	**Housing Intervention Funds (Year Two)**
Base Percentage and Funding	30%	$ 5,733,901.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 5,733,901.00
Transferred To/From	**Full Service Partnership Percentage (Year Two)**	**Full Service Partnership Funds (Year Two)**
Base Percentage and Funding	35%	$ 6,689,551.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 6,689,551.00
Transferred To/From	**Behavioral Health Services and Support Percentage (Year Two)**	**Behavioral Health Services and Support Funding (Year Two)**
Base Percentage and Funding	35%	$ 6,689,551.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 6,689,551.00

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 (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year Three)		
Base Component	**Housing Intervention Percentage (Year Three)**	**Housing Intervention Funds (Year Three)**
Base Percentage and Funding	30%	$ 5,695,539.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 5,695,539.00
Transferred To/From	**Full Service Partnership Percentage (Year Three)**	**Full Service Partnership Funds (Year Three)**
Base Percentage and Funding	35%	$ 6,644,796.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 6,644,796.00
Transferred To/From	**Behavioral Health Services and Support Percentage (Year Three)**	**Behavioral Health Services and Support Funding (Year Three)**
Base Percentage and Funding	35%	$ 6,644,796.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 6,644,796.00

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	$ 4,700,000.00	$ -	$ 700,000.00	$ 4,000,000.00
PEI	$ 3,000,000.00	$ -	$ -	$ 3,000,000.00
Encumbered INN	$ 600,000.00	$ 125,000.00	$ -	$ 475,000.00
Unencumbered INN	$ 1,974,000.00	$ -	$ 1,974,000.00	$ -
WET	$ 770,000.00			$ 770,000.00
CFTN	$ 5,300,000.00			$ 5,300,000.00
Total (auto-populated)	$ 16,344,000.00	$ 125,000.00	$ 2,674,000.00	$ 13,545,000.00

Excess Prudent Reserve to BHSA Components	
Transfer from Prudent Reserve to BHSA Component Allocation	**Amount**
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$ 2,175,490.00
Local Prudent Reserve Maximum (2)	$ 3,787,716.15
Excess Prudent Reserve Funding that must be transferred	**$ (1,612,226.15)**
Housing Intervention (3)	$ -
FSP	$ -
BHSS (4)	$ -
Total Transferred Excess Prudent Reserve (auto-populated)	$ -

References

1. BHSA County Policy Manual section 6.B.5 states counties may use up to seven percent of Housing Interventions component funds on outreach and engagement. The amount of funds transferred out of the Housing Interventions component into another funding component must be decreased by a corresponding amount. Counties are not required to use Housing Intervention component funding for outreach and engagement, or other funding transfer requests. It remains at the discretion of the counties to transfer up to a total of 14 percent of its BHSA funds in a fiscal year.
2. W&I Code § 5892, subdivision (b)(3)-(4) states a county's prudent reserve must not exceed 20% of average of the total funds distributed to the county Behavioral Health Services Fund over past five years (25% for counties with a population of less than 200,000).
3. W&I Code § 5892, subdivision (b)(6)(B) states prudent reserve funding cannot be spent on capital development.

Instructions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table Five: BHSA Components

	Total Housing Interventions Funding (Year One)	Total Housing Interventions Funding (Year Two)	Total Housing Interventions Funding (Year Three)
Total Estimated Housing Intervention Funding Received (BHSA Funds)	$ 5,854,517.00	$ 5,733,901.00	$ 5,695,539.00
Transfers into Housing Intervention component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Housing Intervention Funding Allocated (MHSA - Unspent Carryover Funds)	$ 125,000.00	$ -	$ -
Total Estimated Housing Intervention Funding (BHSA + MHSA Funds)	$ 5,979,517.00	$ 5,733,901.00	$ 5,695,539.00

Housing Interventions Category

Type of Service	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year One)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Two)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Three)	Projected Expenditures - All Other Funding Sources (Year One)	Projected Expenditures - All Other Funding Sources (Year Two)	Projected Expenditures - All Other Funding Sources (Year Three)
Housing Interventions Component Programs/Services						
Non-Time Limited Permanent Settings (e.g., supportive housing, apartments, single and multi-family homes, shared housing) (2)						
Rental Subsidies	$ 197,842.00	$ 774,512.00	$ 805,566.00	$ 529,344.00	$ -	$ -
Operating Subsidies				$ -	$ -	$ -
Bundled Rental and Operating Subsidies	$ 2,383,126.00	$ 2,413,416.00	$ 2,436,728.00	$ -	$ -	$ -
% of Rental and Operating Subsidies Administered through Flex Pools	9%	20%	22%	20%	0%	0%
Time Limited Interim Settings (e.g., hotel and motel stays, non-congregate interim housing models, recuperative care) (2)						
Rental Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
Bundled Rental and Operating Subsidies	$ 691,000.00	$ 1,263,264.00	$ 1,263,264.00	$ 1,112,799.00		
% of Rental and Operating Subsidies Administered through Flex Pools	0%	0%	0%	0%	0%	0%
Other Housing Interventions						
Other Housing Supports: Landlord Outreach and Mitigation Funds (2)	$ -	$ -	$ -	$ -	$ -	$ -
Other Housing Supports: Participant Assistant Funds (2)	$ -	$ -	$ -	$ -	$ -	$ -
Other Housing Supports: Housing Transition Navigation Services and Housing Tenancy Sustaining Services (2)	$ -	$ -	$ -	$ -	$ -	$ -
Other Housing Supports: Outreach and Engagement (2)	$ 381,000.00	$ 397,085.00	$ 397,085.00	$ -	$ -	$ -
Capital Development Projects	$ 1,362,917.00	$ -	$ -	$ -	$ -	$ -
Housing Flex Pool Expenditures (start-up expenditures)	$ 75,000.00	$ 137,724.00	$ 50,000.00	$ -	$ -	$ -
BHSA Innovative Housing Intervention Pilots and Projects	$ -	$ -	$ -			
MHSA INN Projects	$ 125,000.00	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 5,215,885.00	$ 4,986,001.00	$ 4,952,643.00	$ 1,642,143.00	$ -	$ -

Housing Interventions Transfer Information	Year One	Year Two	Year Three
Transfers out of Housing Intervention component into Local Prudent Reserve (6)	$ -	$ -	$ -

Housing Interventions Component Administrative Information	Year One	Year Two	Year Three
Housing Interventions Component Admin Expenses	$ 763,632.00	$ 747,900.00	$ 742,896.00
Total Housing Interventions Expenditures (auto-populated)	$ 5,979,517.00	$ 5,733,901.00	$ 5,695,539.00
Housing Interventions Populations to be Served	**Year One**	**Year Two**	**Year Three**
Total Housing Interventions Component Funds Dedicated to Chronically Homeless Population (5)	$ 2,929,000.00	$ 2,866,951.00	$ 2,847,770.00
Total Housing Interventions Component Funds Dedicated to Serving Individuals with a SUD only (5)	$ -	$ 319,970.00	$ 331,399.00
Housing Interventions Component Funds Validation (auto-populated based on inputs above)	**Year One**	**Year Two**	**Year Three**
Housing Intervention Component Funds Dedicated to Capital Development/Total Housing Interventions Funding (7) (auto-populated)	23.3%	0.0%	0.0%
Housing Interventions Component Funds Dedicated to Chronically Homeless Population/Total Housing Intervention Component Funding (8) (auto-populated)	50.0%	50.0%	50.0%
Housing Interventions Component Funds Used for Outreach and Engagement (2) (auto-populated)	6.5%	6.9%	7.0%
Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**
Eligible Children/TAY (25 years and younger)	22	38	41
Eligible Adults/Older Adults	147	325	330
Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	**Year One**	**Year Two**	**Year Three**
MHSA "Encumbered" INN	$ 125,000.00	$ -	$ -

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)	$ 6,830,270.00	$ 6,689,551.00	$ 6,644,796.00
Transfers into Full Service Partnership component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Full Service Partnership Funding Allocated (MHSA - Unspent Carryover Funds)	$ 555,300.00	$ 1,388,583.00	$ 730,117.00
Total Estimated Full Service Partnership Funding (BHSA + MHSA Funds)	$ 7,385,570.00	$ 8,078,134.00	$ 7,374,913.00

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)	$ 1,595,991.00	$ 1,643,870.00	$ 1,041,365.00	$ 1,595,991.00	$ 1,643,870.00	$ 1,693,187.00	$ -	$ -	$ 650,000.00
Forensic Assertive Community Treatment (FACT) Fidelity (2)	$ 535,734.00	$ 551,806.00	$ 368,361.00	$ 517,619.00	$ 533,147.00	$ 549,142.00	$ -	$ -	$ 200,000.00
FSP Intensive Case Management	$ 3,090,066.00	$ 3,213,668.00	$ 3,342,215.00	$ 2,385,000.00	$ 2,480,400.00	$ 2,579,616.00	$ -	$ -	
High Fidelity Wraparound	$ 630,000.00	$ 757,900.00	$ 786,637.00	$ 900,000.00	$ 927,000.00	$ 954,810.00	$ 150,000.00	$ 200,000.00	$ 200,000.00
Individual Placement and Support (IPS) Model of Supported Employment (2)	$ 470,444.00	$ 712,453.00	$ 729,623.00	$ 351,922.00	$ 543,719.00	$ 560,031.00	$ -		
Assertive Field-Based Initiation for SUD Treatment Services	$ 100,000.00	$ 150,000.00	$ 150,000.00	$ 10,000.00	$ 12,000.00	$ 12,000.00	$ 50,000.00	$ -	$ -
Other mental health or supportive services not already captured above (e.g., outreach, other recovery-oriented services, peers, etc.): Please define	$ -	$ -	$ -	$ -		$ -	$ -	$ -	$ -
Other substance use disorder treatment services not already captured above (primary SUD FSP programs, innovation, etc.): Please define	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative FSP Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 6,422,235.00	$ 7,029,697.00	$ 6,418,201.00	$ 5,760,532.00	$ 6,140,136.00	$ 6,348,786.00	$ 200,000.00	$ 200,000.00	$ 1,050,000.00
FSP Transfer Information	**Year One**	**Year Two**	**Year Three**						
Transfers out of FSP component into Local Prudent Reserve	$ -	$ -	$ -						
FSP Administrative Information	**Year One**	**Year Two**	**Year Three**						
FSP Component Admin Expenses	$ 963,335.00	$ 1,048,437.00	$ 956,712.00						
Total Full Service Partnership Expenditures (auto-populated)	$ 7,385,570.00	$ 8,078,134.00	$ 7,374,913.00						
Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**						
Eligible Children/TAY (25 years and younger)	115	125	125						
Eligible Adults/Older Adults	400	425	425						
Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	**Year One**	**Year Two**	**Year Three**						
MHSA "Encumbered" INN	$ -	$ -	$ -						

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

Instructions
Counties shall report their projected expenditures of their Behavioral Health Services and Supports funding for their BHSA allocation component, federal financial participation, and all other non-BHSA funding sources in Tab Seven.
Row 26-29: input the total estimated BHSS component allocation received for each year. Row 26 will auto-populate from Tab Four in the BHSA Transfers tab.
Row 27: input the total dollar amount projected to the BHSS funding component from the prudent reserve (if applicable). If you reported on Tab 4, row 138 that you will be transferring excess PR funds to BHSS please report them here.
Input unspent MHSA dollars carried over to this component into row 28. Row 29 will auto-populate the sum of rows 26-28.
Rows 33-46: input the projected expenditures for each BHSS service category or program for each year. Rows 35, 39, and 42 auto-populate from their sub rows.
Row 45: input expenditures for BHSA-funded innovation pilots or projects.
Row 46: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub-allocations above.
Row 47: the subtotal for projected expenditures will be auto-populated from rows 33 - 35, 38, 39, 42, 45, and 46.
Row 49: input the total dollar amount projected to be transferred out of the BHSS funding component into the prudent reserve.
Row 51: enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6. BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Costs).
Row 52: the total for projected BHSS expenditures will be auto-populated from rows 47, 49, and 51.
Row 54: input the total dollar amount of Youth-Focused (25 years and younger) Early Intervention Expenditures.
Row 56: the proportion of EI funds will auto-populate from rows 29 and 35. Note: MHSA WET, INN, and CF/TN funds in Rows 65-67 will be deducted from the revenue (excluded from the denominator).
Row 57: the proportion of Youth-Focused (25 years and younger) EI funds will auto-populate from rows 35 and 54.
Rows 59-60: input the estimated unduplicated count of individuals that will be served across all BHSA-funded programs.
Rows 62-63: input the estimated amount of BHSS funds that will be transferred to WET and CF/TN for each year.
Rows 65-67: auto-populates projected estimated amount of MHSA WET, CF/TN, and Encumbered INN funds that will be available in the BHSA BHSS component for each year.
Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Seven: BHSA Components

	Total Behavioral Health Services and Supports (BHSS) Funding (Year One)	Total Behavioral Health Services and Supports (BHSS) Funding (Year Two)	Total Behavioral Health Services and Supports (BHSS) Funding (Year Three)
Total Estimated Behavioral Health Services and Support Funding Received (BHSA Funds)	$ 6,830,270.00	$ 6,689,551.00	$ 6,644,796.00
Transfers into Behavioral Health Services and Support component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Behavioral Health Services and Support Funding Allocated (MHSA - Unspent Carryover Funds)	$ 7,477,028.00	$ 3,044,320.00	$ 2,548,652.00
Total Estimated Behavioral Health Services and Support Funding (BHSA + MHSA Funds)	$ 14,307,298.00	$ 9,733,871.00	$ 9,193,448.00

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)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Adult and Older Adult System of Care, Excluding Populations Identified in 5892(a)(1) and 5892(a)(2)-Non FSP	$ 2,241,902.00	$ 2,204,253.00	$ 2,170,381.00	$ 1,630,104.00	$ 1,673,007.00	$ 1,714,197.00	$ -	$ -	$ -
Early Intervention Expenditures	$ 4,673,408.00	$ 4,636,387.00	$ 4,180,724.00	$ 460,158.00	$ 633,971.33	$ 837,522.00	$ 359,517.00	$ 359,517.00	$ 359,517.00
Coordinated Specialty Care for First Episode Psychosis	$ 182,386.00	$ 180,546.00	$ 145,000.00	$ 142,386.00	$ 188,546.00	$ 195,000.00	$ 359,517.00	$ 359,517.00	$ 359,517.00
All Other EI Expenditures	$ 4,491,022.00	$ 4,455,841.00	$ 4,035,724.00	$ 317,772.00	$ 445,425.33	$ 642,522.00	$ -	$ -	$ -
Outreach and Engagement	$ 534,569.00	$ 555,952.00	$ 572,631.00	$ 69,008.00	$ 73,054.00	$ 76,000.00	$ -	$ -	$ -
Workforce Education and Training (WET)	$ 146,950.00	$ 146,950.00	$ 146,950.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated BHSA WET funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA WET funds	$ 146,950.00	$ 146,950.00	$ 146,950.00	$ -		$ -	$ -	$ -	$ -
Capital Facilities and Technological Needs (CFTN)	$ 883,211.00	$ 909,707.00	$ 936,998.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated BHSA CF/TN funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA CF/TN funds	$ 883,211.00	$ 909,707.00	$ 936,998.00	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative BHSS Pilots and Projects		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ 475,000.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 8,955,040.00	$ 8,453,249.00	$ 8,007,684.00	$ 2,159,270.00	$ 2,380,032.33	$ 2,627,719.00	$ 359,517.00	$ 359,517.00	$ 359,517.00

BHSS Prudent Reserve Transfer Information	**Year One**	**Year Two**	**Year Three**
Transfers out of BHSS component into Local Prudent Reserve	$ -	$ -	$ -
BHSS Administrative Information	**Year One**	**Year Two**	**Year Three**
BHSS Component Admin Expenses	$ 1,284,015.00	$ 1,280,622.00	$ 1,185,764.00
Total Behavioral Health Services and Supports Expenditures (auto-populated)	$ 10,239,055.00	$ 9,733,871.00	$ 9,193,448.00
Youth-Focused Early Intervention Expenditures	**Year One**	**Year Two**	**Year Three**
Total Youth-Focused (25 years and younger) Early Intervention Expenditures	$ 2,383,439.00	$ 2,364,558.00	$ 2,132,170.00
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)	60.2%	98.8%	80.2%
Youth-Focused (25 years and younger) Early Intervention Expenditures/Total Allocated Early Intervention Funds (3)	51.0%	51.0%	51.0%
Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**
Eligible Children/TAY (25 years and younger)	1270	1285	1300
Eligible Adults/Older Adults	7995	1513	1551
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	$ 770,000.00	$ 623,050.00	$ 476,100.00
Estimated MHSA CF/TN Funds	$ 5,300,000.00	$ 4,416,789.00	$ 3,507,082.00

MHSA "Encumbered" INN	$ 475,000.00	$ -	$ -

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 [illegible]
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	$ 222,433.00	$ 231,330.00	$ 240,584.00
Total Projected County Integrated Plan Annual Planning Expenditures	$ 93,239.00	$ 96,969.00	$ 100,847.00
New and Ongoing Administrative Costs	$ 412,055.00	$ 428,537.00	$ 445,679.00
Select County Population Size:	More than 200k		
Administrative Information Validation			
Total Projected Annual Revenues of Local Behavioral Health Services Fund	$ 19,515,057.00	$ 19,113,003.00	$ 18,985,131.00
Improvement and Monitoring Expenditures/Total Annual Revenues of Local Behavioral Health Services Fund (auto-populated)	1.1%	1.2%	1.3%
Total Projected Planning Expenditures/Total Projected Annual Revenues for Local Behavioral Health Services Fund (auto-populated)	0.5%	0.5%	0.5%
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	$ 2,175,490.00
Local Prudent Reserve Maximum (1)	$ 3,787,716.15
Excess Prudent Reserve Funds (auto-populated)	$ (1,612,226.15)
Total prudent reserve funds above prudent reserve maximum allocated to Housing Interventions	$ -
Total prudent reserve funds above maximum allocated to Full Service Partnerships	$ -
Total prudent reserve funds above maximum allocated to Behavioral Health Services and Supports	$ -
Total Excess Prudent Reserve Funds allocated to BHSA Component Allocations (auto-populated)	$ -
Auto-validation: allocation of all excess Prudent Reserve Funds	NO EXCESS
Total Contributions Into the Local Prudent Reserve (auto-populated)	$ -
Total Distributions From the Local Prudent Reserve (auto-populated)	$ -
References	
1. W&I Code § 5892, subdivision (b)(3)-(4) states a county's prudent reserve must not exceed 20% of average of the total funds distributed to the county Behavioral Health Services Fund over past five years (25% for counties with a population of less than 200,000).	

Instructions

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

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

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

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

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

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

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

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

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

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

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

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

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

Table Ten: BHSA Funding Summary (auto-populated)				
	Housing Interventions	Full-Service Partnerships	Behavioral Health Services and Supports	Total
Year One				
Allocation Percentage, with Transfers	30%	35%	35%	100%
Component Allocations	$ 5,854,517.00	$ 6,830,270.00	$ 6,830,270.00	$ 19,515,057.00
Year Two				
Allocation Percentage, with Transfers	30%	35%	35%	100%
Component Allocations	$ 5,733,901.00	$ 6,689,551.00	$ 6,689,551.00	$ 19,113,003.00
Year Three				
Allocation Percentage, with Transfers	30%	35%	35%	100%
Component Allocations	$ 5,695,539.00	$ 6,644,796.00	$ 6,644,796.00	$ 18,985,131.00

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)*	$ 5,854,517.00	$ 6,830,270.00	$ 6,830,270.00	$ 19,515,057.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds) *(Unspent Carryover MHSA Funds)*	$ 125,000.00	$ 555,300.00	$ 7,477,028.00	$ 8,157,328.00
Estimated Total Available Funding for Year One	$ 5,979,517.00	$ 7,385,570.00	$ 14,307,298.00	$ 27,672,385.00
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year One Expenditures	$ 5,979,517.00	$ 7,385,570.00	$ 10,239,055.00	$ 23,604,142.00

BHSA Funding Summary (Year Two)				
	Housing Interventions (Year Two)	Full Service Partnerships (Year Two)	Behavioral Health Services and Supports (Year Two)	Year Two Totals
Estimated New Year Two Component Allocations *(BHSA Funding Only)*	$ 5,733,901.00	$ 6,689,551.00	$ 6,689,551.00	$ 19,113,003.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ -	$ 1,388,583.00	$ 7,112,563.00	$ 8,501,146.00
Estimated Total Available Funding for Year Two	$ 5,733,901.00	$ 8,078,134.00	$ 13,802,114.00	$ 27,614,149.00
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year Two Expenditures	$ 5,733,901.00	$ 8,078,134.00	$ 9,733,871.00	$ 23,545,906.00

BHSA Funding Summary (Year Three)				
	Housing Interventions (Year Three)	Full Service Partnerships (Year Three)	Behavioral Health Services and Supports (Year Three)	Year Three Totals
Estimated New Year Three Component Allocations *(BHSA Funding Only)*	$ 5,695,539.00	$ 6,644,796.00	$ 6,644,796.00	$ 18,985,131.00

Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ -	$ 730,117.00	$ 6,616,895.00	$ 7,347,012.00
Estimated Total Available Funding for Year Three	$ 5,695,539.00	$ 7,374,913.00	$ 13,261,691.00	$ 26,332,143.00
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year Three Expenditures	$ 5,695,539.00	$ 7,374,913.00	$ 9,193,448.00	$ 22,263,900.00

BHSA Plan Admin Expenses

Plan Admin Category	Year One	Year Two	Year Three	Total
Total Projected Improvement and Monitoring Expenditures	$ 222,433.00	$ 231,330.00	$ 240,584.00	$ 694,347.00
Total Projected County Integrated Plan Annual Planning Expenditures	$ 93,239.00	$ 96,969.00	$ 100,847.00	$ 291,055.00
Total Projected New and Ongoing Administrative Expenditures	$ 412,055.00	$ 428,537.00	$ 445,679.00	$ 1,286,271.00

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 Conponents): Added unspent MHSA funds row for year 1, 2 and 3.	10/25/2025
2.0	10/25/2025	Tab 7 (BHSS): Added separate rows for unspent MHSA WET/CFTN expenditures.	10/25/2025
2.0	10/25/2025	Tabs 1-10: Fixed formula and instruction errors	10/25/2025
3.0	2/18/2026	Tab 4 (BHSA Transfers): Added Year 2 and Year 3 for exemption requests	2/18/2026
3.0	2/18/2026	Tab 4 (BHSA Transfers): Added validation check for funding transfers	2/18/2026
3.0	2/18/2026	Tab 4 (BHSA Transfers): Added two new rows for unspent MHSA “Encumbered” INN Funds and unspent MHSA “Unencumbered” INN Funds.	2/18/2026
3.0	2/18/2026	Tab 5, 6 and 7 (BHSA Components): Moved transfers from prudent reserve into the BHSA component funding section to be included with total revenue	2/18/2026
3.0	2/18/2026	Tab 5, 6, and 7 (BHSA Components): Included prudent reserve transfers as an expenditure	2/18/2026
3.0	2/18/2026	Tab 5, 6, and 7 (BHSA Components): Included prudent reserve transfers as an expenditure	2/18/2026
3.0	2/18/2026	Tab 5, 6 and 7 (BHSA Components): Added a row for projected MHSA “Encumbered” INN Project expenditures.	2/18/2026
3.0	2/18/2026	Tab 5 (Housing Interventions): Removed projected encumbered MHSA INN fund expenditures from the 50% HI funds dedicated to chronically homeless suballocation requirement calculation	2/18/2026
3.0	2/18/2026	Tab 7 (BHSS): Removed projected encumbered MHSA INN fund expenditures from the 51% BHSS funds dedicated to Early Intervention suballocation requirement calculation	2/18/2026
3.0	2/18/2026	Tab 8 (BHSA Plan Admin): Updated to include a validation check for “Improvement and Monitoring” (2% or 4%) and “Planning” (5%)	2/18/2026
3.0	2/18/2026	Tab 9 (Prudent Reserve Assessment): Updated PR validation checks to “No Excess” or “Reduce Excess”	2/18/2026
3.0	2/18/2026	Tab 10 (BHSA Summary): Included component percentage breakdowns for all three years	2/18/2026
3.0	2/18/2026	Tab 10 (BHSA Summary): Include total administrative and planning expenditures from tab 8	2/18/2026

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Behavioral Health Director Certification

Certification

1. I hereby certify that Marin County has complied with all statuses, regulations, and guidelines in preparing and submitting this Three-Year Plan (IP) for Behavioral Health Services and Outcomes, including all fiscal accountability and stakeholder participation requirements. I further certify that:

   - ☑ The information, statements, and attachments included in the Three-Year IP are, to the best of my knowledge and belief, true and correct
   - ☑ I understand and agree that the Department of Health Care Services (DHCS) reserves the right to request clarification regarding unclear or ambiguous statements made in the IP and other supporting documents submitted in the IP
   - ☑ The County will use Behavioral Health Services Act (BHSA) funds to serve the targeted population(s) as described in statute, regulations, and guidance
   - ☑ Behavioral Health funding from all sources will be spent only on allowable uses as stated in statute, statute, regulations, and guidance
   - ☑ BHSA funding will supplement, and not supplant, other funding available from existing state or county funds utilized to provide mental health services or substance use disorder treatment services (except that this non-supplant rule does not apply to the use of 2011 realignment funds provided to counties from the Behavioral Health Subaccount or Behavioral Health Services Growth Special Account)
   - ☑ The IP was submitted to the local behavioral health board

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

   - ○ Yes
   - ◉ No

a. Please describe any implementation challenges or concerns with the BHSA fiscal accountability and stakeholder participation requirements

N/A

County Behavioral Health Agency Director contact information

3. County Name

Marin County

4. Certification for

- (•) Three-Year Integrated Plan
- ( ) Annual Update

5. County Behavioral Health Agency Director name

Todd Schirmer, PhD, CCHP

6. County Behavioral Health Agency Director phone number

(415) 720-4779

7. County Behavioral Health Agency Director email

Todd.Schirmer@MarinCounty.gov

Additional contact information for counties with separate MH and SUD directors (optional)

8. Name

9. Title

10. Phone

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11. Email

County Behavioral Health Agency Director signature

12. Print name

Todd Schirmer

13. Title

Director Behavioral Health & Recovery Services

14. Date

09/19/2025

15. Signature

Todd Schirmer Digitally signed by Todd Schirmer
Date: 2025.09.19 12:52:29 -07'00'

Additional signature for counties with separate MH and SUD directors (optional)

16. Print name

17. Title

18. Date

19. Signature

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County Administrator or Designee Certification

The County Administrator may be known by other titles such as Chief Executive, County Manager, or Chief Administrative Officer. The County Administrator must be the individual who serves as the top staff member in county government and hold the highest level of administrative authority in the county or be the designee of that individual. This individual or their designee must work within the executive office of county government, and they may not be the county behavioral health director.

Certification

1. I hereby certify that:
   - [x] The County will use Behavioral Health Services Act (BHSA) funds to serve the targeted population(s) as described in statute
   - [x] Behavioral Health funding from all sources will be spent only on allowable uses as stated in statute
   - [x] BHSA funding will supplement, and not supplant, other funding available from existing state or county funds utilized to provide mental health services or substance use disorder treatment services (except that this non-supplant rule does not apply to the use of 2011 realignment funds provided to counties from the Behavioral Health Subaccount or Behavioral Health Services Growth Special Account)

2. Does the county wish to disclose any implementation challenges or concerns with these requirements?
   - ( ) Yes
   - (x) No

a. If answered yes above, please describe any implementation challenges or concerns with the BHSA fiscal accountability and stakeholder participation requirements

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Signature

3. Print name

Derek Johnson

4. Date

9/29/2025September, 29, 2025

5. Signed by:

Derek Johnson

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Contact information

6. County Name

Marin County

7. Certification for

- [x] Three-Year Integrated Plan
- [ ] Annual Update

8. County Chief Administration Officer Name

Derek Johnson

9. County Chief Administration Officer Phone number

(415) 473-6358

10. County Chief Administration Officer Email

derek.johnson@marincounty.gov

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Board of Supervisors Certification

Certification

1. Marin County Board of Supervisors certifies the following:

   ✓ Marin County Board of Supervisors has reviewed and approved this Integrated Plan for the period of FY26/27-FY28/29

   ✓ 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

   Mary Sackett

4. Title

   President, Marin County Board of Supervisors

5. Date

December 9, 2025

6. Signature

Mary Packett