sonoma county
DEPARTMENT OF HEALTH SERVICES

Supplemental Daily Patch Rate Agreement

(to be completed for rates negotiated outside the specified rates in current contract)

This document includes confidential client information. Maintain in accordance with confidentiality policies and procedures.

Contractor Facility Name:	**Start Date of Rate Adjustment:**	**End Date of Rate Adjustment** (90 days max)**:**
Client Name:		**Date of Birth:**
Daily Patch Rate (per contract):	**Supplemental Daily Patch Rate:**	**Total Daily Patch Rate** (Daily Patch Rate + Supplemental Daily Patch Rate)**:**

On _____ the County of Sonoma (County) and _____ (Contractor) entered into a service agreement (Agreement) for the provision of services as set forth in Agreement. County and Contractor desire to enter into this Supplemental Patch Rate Agreement (Patch Rate Agreement) for the provision of additional support services to the Client at Contractor's facility identified above.

Sonoma County Department of Health Services, Behavioral Health Division (SCBH) agrees to pay the above temporary additional Supplemental Daily Patch Rate (SDPR) to Contractor for the express purpose of increasing support services and developing interventions designed to address behaviors exhibited by the client that put him/her at risk of losing this placement. These additional support services and SDPR will commence on the date noted in the "Start Date of Rate Adjustment" through the "End Date of Rate Adjustment" set forth above. **The term of this Patch Rate Agreement shall not exceed ninety 90 days.** Upon expiration of this SDPR, SCBH and Contractor may elect to enter into a new SDPR for continued provision of enhanced services.

The Contractor's facility will identify targeted behaviors warranting the SDPR and provide a description of additional support services and interventions aimed at ameliorating targeted behaviors. These target behaviors and interventions will be listed by Contractor on the Facility Plan with a copy provided to SCBH. SCBH will evaluate progress by reviewing facility treatment notes/reports describing support service activities, interventions, and outcomes; interviewing staff and client to determine whether the client: 1) is progressing using identified support services and interventions and would benefit from continuation, or 2) is not progressing with identified support services and interventions requiring change to support services and interventions provided by Contractor's facility or 3) targeted behaviors have been ameliorated, 4) there is no longer risk of losing placement, and 5) current behavior is considered normative for Facility Residents. Contractor agrees to fully cooperate with County in its evaluation of Client's progress.

I hereby certify that I have the authority to approve the SDPR for the Client indicated in this Patch Rate Agreement. With the exception of the above stated rate and service conditions for this individual Client, all provisions of the Agreement shall remain in full force and effect.

Contractor Representative (please print): _____ Title:_____

Contractor Representative Signature: _____ Date: _____

County Section Manager (please print): _____ Title:_____

County Section Manager Signature: _____ Date: _____

County Representative (please print): _____ Title:_____

County Representative Signature: _____ Date: _____

SCBH Routing Directions: SCBH staff to complete the form, obtain signature from Facility Representative and send to Section Manager for Signature. Section Manager to sign and send a copy to CBID for execution. CBID to review/sign and send to Claiming. Claiming will track rates/expiration dates and send original signed copy to Program Manager to send a copy to the Facility and put original in client's Medical Record.