RESOLUTION NO. 2021 - 8610

A RESOLUTION OF THE BOARD OF SUPERVISORS OF PLUMAS COUNTY

APPROVING BEHAVIORAL HEALTH DEPARTMENT'S MENTAL HEALTH SERVICES ACT (MHSA) PROGRAM AND EXPENDITURE PLAN, 2020-23, AND AUTHORIZING THE DEPARTMENT DIRECTOR TO SUBMIT THE PLAN TO THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES AND SIGNATURE AUTHORITY FOR IMPLEMENTATION OF THE MENTAL HEALTH SERVICES ACT PROGRAM AND EXPENDITURE PLAN, 2020-23.

WHEREAS, Plumas County wants to assure the continuation of Mental Health Services Act (MHSA) funding to provide necessary services for individuals living with mental illnesses and emotional disorders;

WHEREAS, approving a Program and Expenditure Plan for Plumas County Mental Health Services Act (MHSA) is necessary to assure continued MHSA funding;

WHEREAS, California Statute requires the County Board of Supervisors approve the MHSA Program and Expenditure Plan;

NOW, THEREFORE, BE IT RESOLVED that the Board of Supervisors of the County of Plumas, State of California, hereby approves the Plumas County Mental Health Services Act Program and Expenditure Plan, 2020-2023; designates the Plumas County Behavioral Health Department as the county's administrator of this MHSA Plan; and authorizes the Director of Behavioral Health to submit the plan and sign related documents for implementation, reporting, and acquisition of funds for the Plumas County MHSA Program.

Passed and ADOPTED by the County Board of Supervisors of the County of Plumas, State of California, at a regular meeting of said board on the ____ Day of August 2021, by the following vote:

AYES:	Supervisors:	**Ceresola, Hagwood, Thrall, Goss, and Engel**
NOES:	Supervisors:	**None**
ABSENT:	Supervisors:	**None**
ABSTAIN:	Supervisors:	**None**

Jeff Engel, Chair
Board of Supervisors

ATTEST BY:

Heidi Putnam, Clerk of the Board

Approved as to form:

Gretchen Stuhr

2A2

GARY C. ERNST
1526 E. Beech Drive
Visalia, CA 93292
(559) 679-2541 (cell)
(559) 733-1901 (home)

Invoice:

Plumas County Mental Health
Att: Che Shannon

Quincy, CA

				Due
June, 2021	Total Hours:	54.00	@ $120.00	$ 6,480.00

Activity Log:

		Hours
June 1 - 8, 2021	Gen. adm., Cont'd follow-up work on 17 MHSA audit responding to DHCS,preparation for fiscal onsite staff training, Onsite fiscal trainng and orientation of MH/SUDS history, various funding sources,DHCS fiscal reporting requirements, reviewed various internal monitoring tools and reports in prepartation of annual MH and MHSA Cost reposting, reviewed DHCS's MHSA reversion tables and how applied to Plumas program On & offsite (MHSA 3 hrs)	54.00

Vendor #: 28373
Fund/Dept #: 70571
Account #: 521900
Contract #: PCBH GErnst
Date: 7-9-2021

SIGNATURE: Gary C. Ernst

Bal before this bill $ 0

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PLUMAS COUNTY MENTAL HEALTH
SUITE 109
270 COUNTY HOSPITAL ROAD
QUINCY, CA 95971

RECEIVED
JUL 02 2021
BY:

2A3

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [X] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE [redacted] YY SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) [redacted]

6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street) [redacted]

CITY [redacted] STATE CA

8. RESERVED FOR NUCC USE

CITY [redacted] STATE

ZIP CODE

TELEPHONE (Include Area Code) [redacted]

ZIP CODE

TELEPHONE (Include Area Code) [redacted]

9. OTHER INSURED'S NAME (Last Name. First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH SEX M [ ] F [X]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes,* complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 06192021

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN MANOLITO B FIDEL MD

17a.

17b. NPI 1326098534

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 04262021 TO 05012021

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0

A. F32.9 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 04272021	04272021	21		99222		A	350.00	1		NPI	1326098534
2 04282021	04282021	21		99232		A	175.00	1		NPI	1326098534
3 04292021	04292021	21		99232		A	175.00	1		NPI	1326098534
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER 201288074 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO. 2

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $ 700.00

29. AMOUNT PAID $ 0.00

30. Rsvd for NUCC use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
MANOLITO B FIDEL MD
06192021
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
DEL AMO BEHAVIORAL HEALTH
23700 CAMINO DEL SOL
TORRANCE, CA 90505-5017
a. 1245203447 b.

33. BILLING PROVIDER INFO & PH. # ( ) 4244007748
MANOLITO B FIDEL MD INC
28919 COVECREST DRIVE
RANCHO PALOS VERDES, CA 90275-4703
a. 1679859359 b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB 0938-1197 FORM 1500 (02-12)

WCMS-1500CS-12 7/2/21

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS SECOND FOLD CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PLUMAS COUNTY MENTAL HEALTH
SUITE 109
270 COUNTY HOSPITAL ROAD
QUINCY, CA 95971

PICA | PICA

1. MEDICARE | MEDICAID | TRICARE | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER
( ) (Medicare #) | ( ) (Medicaid #) | ( ) (ID#/DoD#) | ( ) (Member ID#) | ( ) (ID#) | ( ) (ID#) | (X) (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE SEX
M ( ) F (X)

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED
Self (X) Spouse ( ) Child ( ) Other ( )

7. INSURED'S ADDRESS (No., Street)

CITY | STATE: CA

8. RESERVED FOR NUCC USE

CITY | STATE: CA

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous)
( ) YES (X) NO

a. INSURED'S DATE OF BIRTH SEX
M ( ) F (X)

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State)
( ) YES (X) NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT?
( ) YES (X) NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
( ) YES (X) NO *If yes,* complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 06192021

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
DN MANOLITO B FIDEL MD

17a.

17b. NPI 1326098534

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 04262021 TO 05092021

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? $ CHARGES
( ) YES (X) NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0
A. F32.9 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	05	03	2021	05	03	2021	21		99232		A	175.00	1		NPI	1326098534
2	05	04	2021	05	04	2021	21		99232		A	175.00	1		NPI	1326098534
3	05	05	2021	05	05	2021	21		99232		A	175.00	1		NPI	1326098534
4	05	06	2021	05	06	2021	21		99232		A	175.00	1		NPI	1326098534
5	05	07	2021	05	07	2021	21		99232		A	175.00	1		NPI	1326098534
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN
201288074 ( ) (X)

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back)
(X) YES ( ) NO

28. TOTAL CHARGE $ 875.00

29. AMOUNT PAID $ 0.00

30. Rsvd for NUCC use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
MANOLITO B FIDEL MD
06192021
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
DEL AMO BEHAVIORAL HEALTH
23700 CAMINO DEL SOL
TORRANCE, CA 90505-5017
a. 1245203447 b.

33. BILLING PROVIDER INFO & PH # (4244007748)
MANOLITO B FIDEL MD INC
28919 COVECREST DRIVE
RANCHO PALOS VERDES, CA 90275-4703
a. 1679859359 b.

NUCC Instruction Manual available at: www.nucc.org

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7/2/21

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SECOND FOLD

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PLUMAS COUNTY MENTAL HEALTH
SUITE 109
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QUINCY, CA 95971

RECEIVED
JUL 0 9 2021
BY: ..... PICA

CARRIER

1. MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
( ) (Medicare #)	( ) (Medicaid #)	( ) (ID#/DoD#)	( ) (Member ID#)	( ) (ID#)	( ) (ID#)	(X) (ID#)	

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
V	M ( ) F (X)	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED: Self (X) Spouse ( ) Child ( ) Other ( )	7. INSURED'S ADDRESS (No., Street)
CITY	STATE: CA	8. RESERVED FOR NUCC USE
ZIP CODE	TELEPHONE (Include Area Code)	

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES ( ) NO (X)	a. INSURED'S DATE OF BIRTH SEX M ( ) F (X)
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES ( ) NO (X) PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES ( ) NO (X)	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ( ) NO (X) *If yes,* complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 06242021

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SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN MANOLITO B FIDEL MD	17a. 17b. NPI 1326098534	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 04262021 TO 05022021
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES ( ) NO (X) $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0 A. F32.9 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 04302021	04302021	21		99232		A	175.00	1		NPI	1326098534
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC use
201288074	( ) (X)		(X) YES ( ) NO	$ 175.00	$ 0.00	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # 4244007748
MANOLITO B FIDEL MD SIGNED 06242021 DATE	DEL AMO BEHAVIORAL HEALTH 23700 CAMINO DEL SOL TORRANCE, CA 90505-5017 a. 1245203447 b.	MANOLITO B FIDEL MD INC 28919 COVECREST DRIVE RANCHO PALOS VERDES, CA 90275-4703 a. 1679859359 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

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