

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;

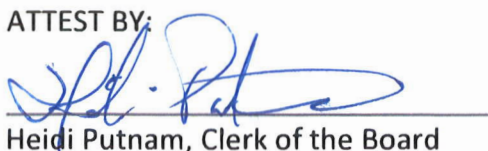
WHEREAS, California Statute requires the County Board of Supervisors approve the MHSA Program and Expenditure Plan;

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.

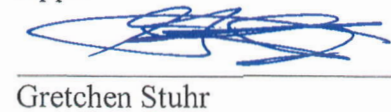
Passed and ADOPTED by the County Board of Supervisors of the County of Plumas, State of California, at a regular meeting of said board on the ____ Day of August 2021, by the following vote:

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

June, 2021	Total Hours:	54.00 @ \$120.00	<u>Due</u> \$6,480.00
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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 training and orientation of MH/SUDS history, various funding sources, DHCS fiscal reporting requirements, reviewed various internal monitoring tools and reports in preparation 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
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SIGNATURE:

Gary C. Ernst

Vendor #: 28373
Fund/Dept #: 70571
Account #: 521900
Contract #: PCMH GME Ernst
Date: 7-9-2021

*Bal before this
bill \$ @*



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

RECEIVED

2A3 02 2021
BY:

HEALTH INSURANCE CLAIM FORM

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

PICA		PICA	
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare #) (Medicaid #) (ID#/DoD#) (Member ID#) (ID#) (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 YY M F	
4. INSURED'S NAME (Last Name, First Name, Middle Initial)		5. PATIENT'S ADDRESS (No., Street) CITY STATE CA ZIP CODE TELEPHONE (Include Area Code)	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)	
8. RESERVED FOR NUCC USE		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER	
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. SIGNATURE ON FILE SIGNED _____ 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. SIGNATURE ON FILE SIGNED _____	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.		15. OTHER DATE MM DD YY QUAL.	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN MANOLITO B FIDEL MD	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 04262021 YY TO 05012021 YY		19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	
20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) 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 To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) 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			
5			
6			
25. FEDERAL TAX I.D. NUMBER SSN EIN 201288074		26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> 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	
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. # MANOLITO B FIDEL MD INC 28919 COVECREST DRIVE RANCHO PALOS VERDES, CA 90275-4703 a. 1679859359 b.	

7/2/21



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

HEALTH INSURANCE CLAIM FORM

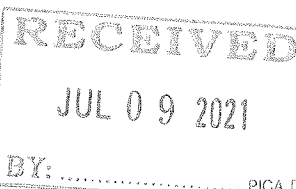
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA		PICA	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (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 YY MM DD SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	
5. PATIENT'S ADDRESS (No., Street)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
CITY		7. INSURED'S ADDRESS (No., Street)	
STATE CA		CITY	
ZIP CODE		STATE CA	
TELEPHONE (Include Area Code)		ZIP CODE	
TELEPHONE (Include Area Code)		TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
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.		11. INSURED'S POLICY GROUP OR FECA NUMBER	
SIGNATURE ON FILE		a. INSURED'S DATE OF BIRTH YY MM DD SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	
SIGNED		b. OTHER CLAIM ID (Designated by NUCC)	
DATE 06192021		c. INSURANCE PLAN NAME OR PROGRAM NAME	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a and 9d.	
15. OTHER DATE MM DD YY QUAL		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN MANOLITO B FIDEL MD		SIGNATURE ON FILE	
17a. 17b. NPI 1326098534		SIGNED	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		DATE	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) F32.9		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
A. B. C. D. E. F. G. H. I. J. K. L.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 04262021 YY TO 05092021 YY	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	
1 05032021 05032021 21 99232 A 175.00 1 NPI 1326098534		22. RESUBMISSION CODE ORIGINAL REF. NO.	
2 05042021 05042021 21 99232 A 175.00 1 NPI 1326098534		23. PRIOR AUTHORIZATION NUMBER	
3 05052021 05052021 21 99232 A 175.00 1 NPI 1326098534			
4 05062021 05062021 21 99232 A 175.00 1 NPI 1326098534			
5 05072021 05072021 21 99232 A 175.00 1 NPI 1326098534			
6			
25. FEDERAL TAX ID. NUMBER 201288074 SSN EIN <input checked="" type="checkbox"/> X		27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
26. PATIENT'S ACCOUNT NO.		28. TOTAL CHARGE \$ 875.00	
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.) MANOLITO B FIDEL MD 06192021		29. AMOUNT PAID \$ 0.00	
32. SERVICE FACILITY LOCATION INFORMATION DEL AMO BEHAVIORAL HEALTH 23700 CAMINO DEL SOL TORRANCE, CA 90505-5017 1245203447		30. Rsvd for NUCC use	
33. BILLING PROVIDER INFO & PH. # 4244007748 MANOLITO B FIDEL MD INC 28919 COVECREST DRIVE RANCHO PALOS VERDES, CA 90275-4703 1679859359			

7/2/21



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2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)	
CITY		8. RESERVED FOR NUCC USE		CITY	
STATE CA				STATE CA	
ZIP CODE		TELEPHONE (Include Area Code)		ZIP CODE	
TELEPHONE (Include Area 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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> 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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a and 9d.	
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.					
SIGNATURE ON FILE			SIGNATURE ON FILE		
SIGNED			DATE		
06242021					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)			15. OTHER DATE		
MM DD YY QUAL			MM DD YY QUAL		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		
DN MANOLITO B FIDEL MD			FROM 04262021 TO 05022021		
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			20. OUTSIDE LAB? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E)			22. RESUBMISSION CODE		
F32.9			ORIGINAL REF. NO.		
A. B. C. D. E. F. G. H. I. J. K. L.			23. PRIOR AUTHORIZATION NUMBER		
24. A. DATE(S) OF SERVICE			24. B. PLACE OF SERVICE		
From To			EMG CPT/HCPCS MODIFIER		
MM DD YY MM DD YY			DIAGNOSIS POINTER		
1 04302021 04302021 21			A		
2					
3					
4					
5					
6					
25. FEDERAL TAX I.D. NUMBER			26. PATIENT'S ACCOUNT NO.		
201288074			1245203447		
27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			28. TOTAL CHARGE		
			175.00		
29. AMOUNT PAID			30. Rsvd for NUCC use		
0.00					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER			32. SERVICE FACILITY LOCATION INFORMATION		
MANOLITO B FIDEL MD			DEL AMO BEHAVIORAL HEALTH		
06242021			23700 CAMINO DEL SOL		
			TORRANCE, CA 90505-5017		
SIGNED			33. BILLING PROVIDER INFO & PH #		
DATE			MANOLITO B FIDEL MD INC		
			28919 COVECREST DRIVE		
			RANCHO PALOS VERDES, CA 90275-4703		
			1679859359		