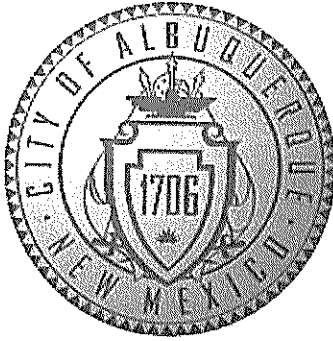


EC-22-168




Mayor Timothy M. Keller

CITY OF ALBUQUERQUE
Albuquerque, New Mexico
Office of the Mayor

INTER-OFFICE MEMORANDUM

October 5, 2022

TO: Isaac Benton, President, City Council

FROM: Timothy M. Keller, Mayor 

SUBJECT: Authorization to Supplement a Professional Technical Agreement with Albuquerque Behavioral Health to Provide Substance Use Treatment

The Department of Family & Community Services, Behavioral Health & Wellness Division, is supplementing an existing agreement with Albuquerque Behavioral Health (ABH), an agency eligible to contract through professional/technical services contract as a network substance use treatment provider. The supplemental agreement for ABH is in the total amount of \$500,000, and is based on the past fiscal years' billable services. ABH is a for-profit entity and meets performance standards as set forth in the Albuquerque Minimum Standards for Substance use Treatment Services.

Licensed agency clinicians perform comprehensive drug and alcohol assessments on all applicants seeking admission into their program. Once the client is approved, a voucher subsidizing treatment services is issued for the client, and contractors receive payment from the General Fund for the treatment services they provide.

The Department of Family & Community Services has already established units of service and service rates. All together, the contracts for network providers under this substance use treatment voucher program will not exceed the total available fund allocated in the FY-23 budget for substance use treatment vouchers.

The Department of Family & Community Services respectfully forwards this request to the Council for consideration and action.

Carol M. Pierce
Director, Dept. of Family & Community Services

Cover Analysis

1. What is it?

Request for authorization to execute a supplemental agreement with Albuquerque Behavioral Health to provide substance use treatment.

2. What will this piece of legislation do?

Authorize the supplemental agreement with Albuquerque Behavioral Health.

3. Why is this project needed?

Approval will allow the agency to continue to provide substance use treatment services to eligible clients, who need such services as determined by a clinical assessment.

4. How much will it cost and what is the funding source?

Up to \$500,000 of the City General Fund. The total cost of the treatment services at each treatment provider site is unknown until the end of the fiscal year, because it is not possible to predict how many referrals each provider may receive. The funding source is the City General Fund, and the total amount reimbursed does not exceed the allocated FY-23 Budget line item.

5. Is there a revenue source associated with this legislation? If so, what level of income is projected?

No.

6. What will happen if the project is not approved?

Clients served by this provider will not be able to continue receiving subsidized Substance Use Treatment services, which will hinder their recovery process.

7. Is this service already provided by another entity?

No.

FISCAL IMPACT ANALYSIS

TITLE: Authorization to Supplement a Professional
Technical Agreement with Albuquerque
Behavioral Health to Provide Substance Use
Treatment

R: O:

FUND: 110

DEPT: FCS/2923812

- ☒ No measurable fiscal impact is anticipated, i.e., no impact on fund balance over and above existing appropriations.
- ☐ (If Applicable) The estimated fiscal impact (defined as impact over and above existing appropriations) of this legislation is as follows:

	2023	Fiscal Years		2025	Total
		2024			
Base Salary/Wages	-				-
Temporary Wages	-				-
Fringe Benefits at	-			-	-
Fringe Benefits at	-	-			-
Subtotal Personnel	-	-		-	-
Operating Expenses	-				-
Property	-	-		-	-
Indirect Costs	-				-
Total Expenses	\$ -	\$ -	\$ -	\$ -	-
<hr/>					
[X] Estimated revenues not affected					
[] Estimated revenue impact					
Amount of Grant	-	-			-
City Cash Match	-				-
City Inkind Match			-		-
City IDOH	-	-			-
Total Revenue	\$ -	\$ -	\$ -	\$ -	-

These estimates do not include any adjustment for inflation.

* Range if not easily quantifiable.

Number of Positions created

COMMENTS:

The Department of Family & Community Services, Behavioral Health & Wellness Division, is supplementing an existing agreement with Albuquerque Behavioral Health (ABH), an agency eligible to contract through professional/technical services contract as a network substance use treatment provider. The supplemental agreement for ABH is in the total amount of \$500,000, and is based on the past fiscal years' billable services. ABH is a for-profit entity and meets performance standards as set forth in the Albuquerque Minimum Standards for Substance use Treatment Services.

COMMENTS ON NON-MONETARY IMPACTS TO COMMUNITY/CITY GOVERNMENT:

Funds were appropriated in the FY 23 Budget in the Substance Abuse Program -2900015 - R - 22-24.

PREPARED BY:

APPROVED:

FISCAL MANAGER

DIRECTOR (date)

REVIEWED BY:

EXECUTIVE BUDGET ANALYST

BUDGET OFFICER (date)

CITY ECONOMIST



CITY OF ALBUQUERQUE

Department of Family and Community Services


Carol M. Pierce, Director

Timothy M. Keller, Mayor

Interoffice Memorandum

August 16, 2022

To: Lawrence Rael, Chief Administrative Officer
Jennifer L. Bradley, Chief Procurement Officer

From: Carol M. Pierce, Director 
Department of Family and Community Services

Subject: Request for Approval of Purchase of Professional Technical Service
Exceeding \$55,000 in One Fiscal Year for Albuquerque Behavioral Health

Pursuant to Administrative Instruction 1-1, Section III.B.2., for all professional/technical contracts that will exceed \$55,000 in one fiscal year, Departments shall prepare a form explaining how the Department arrived at the best obtainable price for the services. With this memorandum, the Department of Family and Community Services (DFCS) wishes to enter into a professional/technical agreement with Albuquerque Behavioral Health (ABH) for the purpose of providing substance use treatment as part of the substance use treatment provider network to residents who are not enrolled in Medicaid or who do not receive full Medicaid funding, and need financial support for substance use treatment services. Criteria for this program includes the following: clients must actively need substance use disorder treatment, must not currently be receiving full Medicaid benefits, must not be receiving substance use treatment through other funding sources, and must be considered very low income according to federal HUD guidelines.

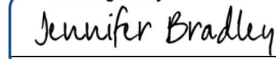
DFCS provides the following explanation of how it arrived at the best obtainable price and service provider: the Division of Behavioral Health and Wellness (DBHW) determines the fee schedule for the substance use treatment provider network, based on local reimbursement rates, and the fee is non-negotiable by applicants to the network. Additionally, the Department has a non-exclusionary, open application process throughout the year, and any new provider who applies and meets established requirements for provision of services may be a network contract provider. Current providers that are re-applying must meet performance standards as set forth in the *Albuquerque Minimum Standards for Substance Abuse Treatment Services*. Network providers include both non-profit and for-profit providers. DBHW has received applications from several providers, one of which was ABH, which met eligibility to contract through professional/technical services contracts as a network substance use treatment provider.

In submitting this Request for Approval, I agree that I have reviewed and will comply with

the rules of ethical conduct set out in the City's Conflict of Interest Code at Sections 3-3-1 *et seq.* and the Purchasing Ordinance at Sections 5-5-22 *et seq.* ROA 1994.

APPROVED:

DocuSigned by:



Jennifer L. Bradley

Chief Procurement Officer

Date: 8/19/2022 | 9:51 AM MDT

DocuSigned by:



Lawrence Rael,

Chief Administrative Officer

Date: 8/22/2022 | 3:32 PM MDT

CONTRACT CONTROL FORM

Contact: Sandra A Archuleta
Phone:

Req. Num.:
Acct. Num.:
Act. Num.:

CCN: 202201458

PRELIMINARY

Type of Agreement: Professional/Technical Services

For Grants Only:
Indirect Costs for General Fund
Services

Description: Subsidy for OP SU Tx Cts
Dept/Div: /

% _____
\$ _____

Vendor: Albuquerque Health Services LLC dba/ Albuquerque Behavioral Health Contract Term: 07/01/2022 to: 06/30/2023

Contract Amount: \$100,000.00 Payable
Contract Total:

FY Aggregate: \$100,000.00

Date Submitted: 06/29/2022

PROCUREMENT:**WAIVERS REQUIRED:**

RFP: No

Waiver Letter Attached: _____ Approved: _____

Ins:

Waiver Letter Attached: _____ Approved: _____

DRAFT CONTRACT:

Recd by Legal: _____ Rejected/Returned to Dept: _____ / _____

Returned to Legal: _____ / _____ Approved: _____ Initials: _____

INSURANCE AND BONDS REQUIRED:

Bonds Required: NONE

Attached: _____

Insurance Required: Worker's Compensation; Commercial General Liability; Attached: _____

Automobile Liability;

FINAL CONTRACT REVIEW

APPROVALS REQUIRED:	Date Delivered	Returned to Dept.	Approved by	Approval Date	Approved by	Approval Date
Purchasing:			<u>DS</u> <u>JB</u>	7/6/2022 8:31 AM MDT		
Asst. City Attorney:			<u>DS</u> <u>ME</u>	7/5/2022 4:37 PM MDT	<u>DS</u> <u>PP</u>	7/5/2022 9:47 AM MDT
CIP:						
City Attorney:			<u>DS</u> <u>lk</u>	7/5/2022 5:02 PM MDT		
CAO:			<u>DS</u> <u>LRL</u>	7/6/2022 11:25 AM MDT		
Department:			<u>DS</u> <u>amp</u>	7/5/2022 12:36 PM MDT		
Budget:						
Others:						



AGREEMENT

THIS AGREEMENT is made and entered into upon the date of the last signature below, by and between the City of Albuquerque, New Mexico, a municipal corporation (the "City"), and **Albuquerque Health Services LLC., dba Albuquerque Behavioral Health, 8200 Mountain Rd. NE, Suite 106, Albuquerque, NM, 87110**, a New Mexico corporation (the "Contractor").

RECITALS

WHEREAS, the City has appropriated funds ("City Funds") to provide a subsidy for outpatient substance use treatment services not otherwise covered by a client's public or private insurance; and

WHEREAS, the Contractor is experienced and qualified in the delivery of outpatient substance use treatment services; and

WHEREAS, the Contractor represents that it has the experience, resources and expertise necessary to execute the activities and services desired; and

WHEREAS, the City desires to engage the Contractor to render certain services as described herein, and the Contractor is willing to provide such services; and

WHEREAS, there was a delay in the execution of the Agreement, causing a gap between July 1, 2022 and the execution of the Agreement; and

WHEREAS, the City and the Contractor wish to ratify all actions taken by the parties, consistent with this Agreement from July 1, 2022 to the date of execution of this Agreement.

NOW THEREFORE, in consideration of the premises and mutual obligations herein, the parties hereto do mutually agree as follows:

1. Scope of Services: The Contractor shall perform the following services ("Services") in a satisfactory and proper manner, as determined by the City:
 - A. Provide outpatient substance use treatment, as further defined in the approved FY-23 Application in Exhibit B, for clients eligible to receive a City-subsidized substance use treatment services voucher.
 - B. Provide outpatient substance use treatment services in accordance with the service rates established by the City in the current Voucher Clinical Service Specifications for the City of Albuquerque Voucher System for the duration of the treatment voucher. Services shall be based on current research and evidence demonstrating that the treatment approach is a sound, culturally appropriate, and age appropriate method for addressing substance use problems.

- C. Follow the Treatment Subsidy Voucher System (“System”) rules established by the City (Exhibit A, Treatment Subsidy Voucher System, which is attached hereto and incorporated herein).
- D. Comply with Client Progress Record reporting through the Discharge and Outcomes Report Form as detailed in Exhibit A, Attachment 3 (and/or other reporting that may be implemented as required by the City).
- E. Provide clients with a Confidentiality Statement and obtain any current necessary release(s) of information consistent with 42 CFR Part 2, Confidentiality of Alcohol and Drug Use Patient Records and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) standard for Privacy of Individually Identifiable Health Information, 45 CFR Part 160 and 164, as amended, and any other requirement for release of related information collected by the Contractor.
- F. Adhere to the State of New Mexico Counseling and Therapy Act (the “Act”), Sections 61-9A-1 et seq. NMSA 1978, as currently enacted or hereafter amended. The Contractor must ensure that all persons providing substance use treatment have adequate licensure, pursuant to the Act.
- G. Abide by the current version of the Department of Family and Community Services’ *Albuquerque Minimum Standards for Substance Use Treatment and Prevention Services* and applicable terms in the *Administrative Requirements for Contracts Awarded under the City of Albuquerque*. Failure to do so may result in suspension of this Agreement for a minimum period of thirty (30) days.
- H. If the Services under this Agreement require the Contractor staff to work with or be in proximity to children or other vulnerable populations, the Contractor shall comply with the most current version of the requirements contained in the *Administrative Requirements for Contracts Awarded under the City of Albuquerque Department of Family and Community Services*, effective July 1, 2019, and subject to amendment.
- I. The Contractor’s management and/or clinical supervision staff will attend City-mandated treatment provider meetings.
- J. Enter data on a timely basis in accordance with Exhibit A.
- K. Contractor will adhere to best practices and state and federal regulations when utilizing telehealth services when such services are in the best interest of the health of the client. The Contractor is responsible for remaining current with regard to requirements surrounding telehealth. General state requirements for telehealth can be found at <https://www.hsd.state.nm.us/>, and federal requirements at <https://www.hhs.gov/regulations/index.html>.

- L. The Contractor shall make every effort to bill Medicaid for eligible services in order to maximize services for non-Medicaid clients or non-Medicaid covered expenses as described in the section detailing the use of Program Income in the *Administrative Requirements*.
2. Time of Performance: Services of the Contractor shall commence on July 1, 2022, and shall be undertaken and completed in such sequence as to assure their expeditious completion in light of the purposes of this Agreement; provided, however, that in any event, all of the Services required hereunder shall be completed by June 30, 2023. By signing this Agreement, the parties ratify all actions taken consistent with this Agreement, from July 1, 2022 through to the execution of this Agreement. Further, the parties explicitly agree that all of the terms and conditions of this Agreement, including but not limited to insurance requirements and indemnification, are applicable continuously commencing on July 1, 2022.

If outpatient substance use treatment services for a client are begun prior to June 30, 2023, and outpatient substance use treatment must extend beyond that date, the City shall require the Contractor to: 1) continue to handle to completion any and all treatment begun during the term of this Agreement under a new fiscal year Agreement if a renewal Agreement has been executed, or 2) work with the City to transition the client to another agency in the event the Contractor's Agreement is not renewed beyond June 30, 2023.

3. Compensation and Method of Payment:
- A. Compensation: For performing the Services specified in Section 1 hereof, the City agrees to pay the Contractor for subsidized outpatient substance use treatment service at the rates established for those services set forth in the current Voucher Clinical Services Specifications for the City of Albuquerque Voucher System, which may be amended or updated from time to time. Such rates do not include any applicable gross receipts taxes which may be added and billed to the Contractor during the term of the Agreement. Such payments to the Contractor shall constitute full and complete compensation for the Contractor's Services under this Agreement, including all expenditures made and expenses incurred by the Contractor in performing the Services.
 - B. In order to receive payment, the Contractor must first submit an invoice to the City of Albuquerque. The first Service Period will be from July 1, 2022, through July 9, 2022, and subsequent Service Periods will be for a two (2) week period (Sunday through Saturday), with exceptions noted on Exhibit A, Attachment 2, P.A.T.H. Substance Use Treatment - Provider Network Voucher Program 2022 – 2023 Service Invoicing Schedule, which is attached hereto and incorporated herein.
 - i. The Contractor will be required to submit a Request for Reimbursement (Excel Spreadsheet) every two (2) weeks in conjunction with the P.A.T.H. Substance Use Treatment - Provider Network Voucher Program 2022 –

2023 Service Invoicing Schedule. The Contractor will be required to enter the following information on the Request for Reimbursement:

- a) Agency name
 - b) Agency full address
 - c) Agency POR #
 - d) Billing Period
 - e) Invoice Date
 - f) Client number
 - g) Date of service
 - h) Service Type
 - i) Time of Service
 - j) Number of Service Units
 - k) Total charges – based on current Fee Schedule. The Excel Spreadsheet will automatically total taxes based on current tax rate, for agencies that are for-profit.
- ii. The Contractor must enter the Services during the correct time period in order to be paid. Pre-billing and back-billing are not allowed. Services must have occurred between the start and end of the current Service Period to be paid. Services provided prior to the Service Period cannot be entered and will not be paid.
 - iii. Payment is conditional on availability of funding. As Services are submitted, the amount of available funding is reduced. If Services are not accepted, payment will not be made.
 - iv. After entering the Services, the Contractor must verify an invoice for the Service Period on the fourth (4th) business day by 5:00 pm after the end of the Service Period. Invoice verification can occur every two (2) weeks, but not more frequently.
 - v. Payments shall be made to the Contractor no more often than every two (2) weeks, but no less frequently than monthly, upon receipt by the City of properly documented requisitions for payment as determined by the budgetary and fiscal guidelines of the City and on the condition that the Contractor has accomplished the Services to the satisfaction to the City.
- C. Appropriations: Notwithstanding any provision in this Agreement to the contrary, the terms of this Agreement are contingent upon the City Council of the City of Albuquerque making the appropriations necessary for the performance of this Agreement. If sufficient appropriations and authorizations are not made by the City Council, this Agreement may be terminated at the end of the City's then current Fiscal Year upon written notice given by the City to the Contractor. Such event shall not constitute an event of default. All payment obligations of the City and all

of its interest in this Agreement will cease upon the date of termination. The City's decision as to whether sufficient appropriations are available shall be accepted by the Contractor and shall be final.

- D. **Payment Contingent on Performance:** The scope identifies the expectations of performance and deliverables. Should the Contractor fail to comply with these expectations to the City's satisfaction, the City is entitled to withhold payment or a portion of payment until the Contractor has demonstrated full compliance with the expectations outlined in the Scope.
 - E. **Responsibility to Monitor Contract:** Contractor shall be responsible for ensuring that the Contractor does not bill for Services in an amount that exceeds the total contract amount. With each invoice submitted to the City, the Contractor shall include a ledger report that identifies the total amount the Contractor has billed for Services under this Agreement and any Supplements to this Agreement. If at any time the Contractor determines that payment for Services may or will exceed the total amount provided in this Agreement and any Supplements to this Agreement, the Contractor shall notify the City in writing, as soon as possible after making that determination. If the Contractor's billing exceeds the amount of this Agreement and any Supplements, the City may stop or delay payment, or the Services may be ceased or delayed at the City's request.
4. **Independent Contractor:** Neither the Contractor nor its employees are considered to be employees of the City of Albuquerque for any purpose whatsoever. The Contractor is considered as an independent contractor at all times in the performance of the Services described in Section 1. The Contractor further agrees that neither it nor its employees are entitled to any benefits from the City under the provisions of the Workers' Compensation Act of the State of New Mexico, or to any of the benefits granted to employees of the City under the provisions of the Merit System Ordinance as now enacted or hereafter amended.
5. **Personnel:**
- A. The Contractor represents that it has, or will secure at its own expense, all personnel required in performing all of the Services required under this Agreement. Such personnel shall not be employees of or have any contractual relationships with the City, unless specifically approved by the City.
 - B. All the Services required hereunder will be performed by the Contractor or under its supervision and all personnel engaged in the work shall be fully qualified and shall be authorized or permitted under state and local law to perform such Services.
 - C. None of the work or the Services covered by this Agreement shall be subcontracted without the prior written approval of the City. Any work or Services subcontracted hereunder shall be specified by written contract or Agreement and shall be subject to each provision of this Agreement.

6. Indemnity: The Contractor agrees to defend, indemnify and hold harmless the City and its officials, agents and employees from and against any and all claims, actions, suits or proceedings of any kind brought against said parties because of any injury or damage received or sustained by any person, persons or property arising out of or resulting from the Services performed by the Contractor under this Agreement or by reason of any asserted act or omission, neglect or misconduct of the Contractor or Contractor's agents or employees or any subcontractor or its agents or employees, direct or indirect. The defense and indemnity required hereunder shall not be limited by reason of the specification of any particular insurance coverage in this Agreement.
7. Insurance: The Contractor shall procure and maintain at its own expense until final payment by the City for Services covered by this Agreement, insurance in the kinds and amounts hereinafter provided with insurance companies authorized to do business in the State of New Mexico, covering all operations under this Agreement, whether performed by the Contractor or its agents. Before commencing the Services, and on the renewal of all coverages, the Contractor shall furnish to the City a certificate or certificates in form satisfactory to the City showing that it has complied with this Section. All certificates of insurance shall provide that thirty (30) days written notice be given to the Risk Manager, Department of Finance and Administrative Services, City of Albuquerque, P.O. Box 470, Albuquerque, New Mexico, 87103, before a policy is canceled, materially changed, or not renewed. Various types of required insurance may be written in one or more policies. With respect to all applicable coverages, the City shall be named an additional insured by endorsement onto the policy. Proof of this additional insured relationship shall be evidenced on the Certificate of Insurance (COI) and on the insurance endorsement. All coverages afforded shall be primary with respect to operations provided. Kinds and amounts of insurance required are as follows:
- A. Commercial General Liability Insurance: A commercial general liability insurance policy with combined limits of liability for bodily injury or property damage as follows:
- | | |
|-------------|---|
| \$1,000,000 | Per Occurrence |
| \$2,000,000 | Policy Aggregate |
| \$1,000,000 | Products Liability/Completed Operations |
| \$1,000,000 | Personal and Advertising Injury |
| \$ 5,000 | Medical Payments |
- Said policy of insurance must include coverage for all operations performed for the City by the Contractor and contractual liability coverage shall specifically insure the hold harmless provisions of this Agreement.
- B. Commercial Automobile Liability Insurance ("CAL"): N/A
- C. Workers' Compensation Insurance: Workers' Compensation Insurance for the

Contractor's employees when required by, and in accordance with, the provisions of the Workers' Compensation Act of the State of New Mexico ("Act"). The Contractor must have three (3) or more employees to trigger the Act's workers' compensation insurance requirement. Per the Act, this number includes the owner of the business.

- D. Professional Liability (Errors and Omissions) Insurance: Professional liability (errors and omissions) insurance in an amount not less than \$1,000,000 combined single limit of liability per occurrence with a general aggregate of \$1,000,000.
 - E. Sexual Abuse Molestation Coverage: N/A
 - F. Cyber Liability Coverage: N/A
 - G. Increased Limits: If, during the term of this Agreement, the City requires the Contractor to increase the maximum limits of any insurance required herein, an appropriate adjustment in the Contractor's compensation will be made.
8. Discrimination Prohibited: In performing the Services required hereunder, the Contractor shall not discriminate against any person on the basis of race, color, religion, gender, gender identity, sexual preference, sexual orientation, national origin or ancestry, age, physical handicap, or disability as defined in the Americans with Disabilities Act of 1990, as now enacted or hereafter amended.
 9. ADA Compliance: In performing the Services required hereunder, the Contractor agrees to meet all the requirements of the Americans with Disabilities Act of 1990, as amended and incorporating all applicable rules and regulations (the "ADA"), which are imposed directly on the Contractor or which would be imposed on the City as a public entity. The Contractor agrees to be responsible for knowing all applicable requirements of the ADA and to defend, indemnify and hold harmless the City, its officials, agents and employees from and against any and all claims, actions, suits or proceedings of any kind brought against said parties as a result of any acts or omissions of the Contractor or its agents in violation of the ADA.
 10. Conflict of Interest: No officer, agent or employee of the City will participate in any decision relating to this Agreement which affects that person's financial interest, the financial interest of his or her spouse or minor child or the financial interest of any business in which he or she has a direct or indirect financial interest.
 11. Interest of Contractor: The Contractor agrees that it presently does not have, and shall acquire no direct or indirect interest which conflicts in any manner or degree with the performance of the terms of this Agreement. The Contractor will not employ any person who has any such conflict of interest to assist the Contractor in performing the Services.
 12. No Collusion: The Contractor represents that this Agreement is entered into by the

Contractor without collusion on the part of the Contractor with any person or firm, without fraud and in good faith. The Contractor also represents that no gratuities, in the form of entertainment, gifts or otherwise, were, or during the term of this Agreement, will be offered or given by the Contractor or any agent or representative of the Contractor to any officer or employee of the City with a view towards securing this Agreement or for securing more favorable treatment with respect to making any determinations regarding the performance of this Agreement.

13. Debarment, Suspension, Ineligibility and Exclusion Compliance: The Contractor certifies that it has not been debarred, suspended or otherwise found ineligible to receive funds by any agency of the executive branch of the federal government, the State of New Mexico, any local public body of the State, or any state of the United States. The Contractor agrees that should any notice of debarment, suspension, ineligibility or exclusion be received by the Contractor, the Contractor will notify the City immediately.
14. Reports and Information: At such times and in such forms as the City may require, there shall be furnished to the City such statements, records, reports, data and information, as the City may request pertaining to matters covered by this Agreement. Unless otherwise authorized by the City, the Contractor will not release any information concerning the work product including any reports or other documents prepared pursuant to this Agreement until the final product is submitted to the City.
15. Open Meetings Requirements: Any nonprofit organization in the City which receives funds appropriated by the City, or which has as a member of its governing body an elected official, or appointed administrative official, as a representative of the City, is subject to the requirements of §2-5-1 *et seq.* ROA 1994, Public Interest Organizations. The Contractor agrees to comply with all such requirements, if applicable.
16. Establishment and Maintenance of Records: Records shall be maintained by the Contractor in accordance with applicable law and requirements prescribed by the City with respect to all matters covered by this Agreement. Except as otherwise authorized by the City, such records shall be maintained for a period of three (3) years after receipt of final payment under this Agreement.
17. Audits and Inspections:
 - A. At any time during normal business hours and as often as the City may deem necessary, there shall be made available to the City for examination all of the Contractor's records with respect to all matters covered by this Agreement. The Contractor shall permit the City to audit, examine, and make excerpts or transcripts from such records, and to make audits of all contracts, invoices, materials, payrolls, records of personnel, conditions of employment and other data relating to all matters covered by this Agreement. The Contractor understands and will comply with the City's Accountability in Government Ordinance, §2-10-1 *et seq.* and Inspector General Ordinance, §2-17-1 *et seq.* ROA 1994, and also agrees to provide

requested information and records and appear as a witness in hearings for the City's Board of Ethics and Campaign Practices pursuant to Article XII, Section 8 of the Albuquerque City Charter.

- B. The City will conduct a minimum of two reviews per year of the Contractor's billings. All undocumented/incorrectly documented, but paid Services disclosed as a result of a review or other audit must be reimbursed to the City. All back-billed services will be considered "undocumented" services and must be reimbursed to the City.
18. Ownership, Publication, Reproduction and Use of Material: No material produced in whole or in part under this Agreement shall be subject to copyright in the United States or in any other country. The City shall have unrestricted authority to publish, disclose, distribute and otherwise use, in whole or in part, any reports, data or other materials prepared under this Agreement.
 19. Compliance with Laws: In performing the Services required hereunder, the Contractor shall comply with all applicable laws, ordinances, and codes of the federal, State and local governments. In addition, the Contractor shall comply with the *Administrative Requirements for Contracts Awarded Under the City of Albuquerque, Department of Family and Community Services, Social Services Program*, as amended, and understands that failure to comply with the *Administrative Requirements* shall constitute grounds for termination of this Agreement.
 20. Changes: The City may, from time to time, request changes in the Services to be performed hereunder. Such changes, including any increase or decrease in the amount of the Contractor's compensation, which are mutually agreed upon by and between the City and the Contractor, shall be incorporated in written amendments to this Agreement.
 21. Assignability: The Contractor shall not assign any interest in this Agreement and shall not transfer any interest in this Agreement (whether by assignment or novation), without the prior written consent of the City thereto.
 22. Termination for Cause: If, through any cause, the Contractor shall fail to fulfill in a timely and proper manner its obligations under this Agreement or if the Contractor shall violate any of the covenants, agreements, or stipulations of this Agreement, the City shall thereupon have the right to terminate this Agreement by giving written notice to the Contractor of such termination and specifying the effective date thereof at least five (5) days before the effective date of such termination. In such event, all finished or unfinished documents, data, maps, studies, surveys, drawings, models, photographs and reports prepared by the Contractor under this Agreement shall, at the option of the City, become its property, and the Contractor shall be entitled to receive just and equitable compensation for any work satisfactorily completed hereunder.

Notwithstanding the above, the Contractor shall not be relieved of liability to the City for

damages sustained by the City by virtue of any breach of this Agreement by the Contractor, and the City may withhold any payments to the Contractor for the purposes of set-off until such time as the exact amount of damages due the City from the Contractor is determined.

23. Termination for Convenience of City: The City may terminate this Agreement at any time by giving at least fifteen (15) days' notice in writing to the Contractor. If the Contractor is terminated by the City as provided herein, the Contractor will be paid an amount which bears the same ratio to the total compensation as the Services actually performed bear to the total Services of the Contractor covered by this Agreement, less payments of compensation previously made. If this Agreement is terminated due to the fault of the Contractor, the preceding Section hereof relative to termination shall apply.
24. Force Majeure: The City shall not be liable for failure to perform its obligations under the Contract due to causes beyond the control and without the fault or negligence of either party. Such causes include, but are not restricted to, acts of God or the public enemy, acts of the State or federal government, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes, unusually severe weather and defaults of subcontractors due to any of the above, unless City shall determine that the supplies or services to be furnished by the subcontractor were obtainable from other sources in sufficient time to permit vendor to meet the required delivery scheduled. The rights and remedies of the City provided in this paragraph shall not be exclusive and are in addition to any other rights now being provided by law or under the Contract.
25. Construction and Severability: If any part of this Agreement is held to be invalid or unenforceable, such holding will not affect the validity or enforceability of any other part of this Agreement so long as the remainder of the Agreement is reasonably capable of completion.
26. Enforcement: The Contractor agrees to pay to the City all costs and expenses including reasonable attorney's fees incurred by the City in exercising any of its rights or remedies in connection with the enforcement of this Agreement.
27. Entire Agreement: This Agreement contains the entire agreement of the parties and supersedes any and all other agreements or understandings, oral or written, whether previous to the execution hereof or contemporaneous herewith.
28. Applicable Law and Venue: This Agreement shall be governed by and construed and enforced in accordance with the laws of the State of New Mexico, and the laws, rules and regulations of the City of Albuquerque. The venue for actions arising out of this Agreement is Bernalillo County, New Mexico.
29. Approval Required: This Agreement shall not become binding upon the City until approved by the highest approval authority of the City required under this Agreement.

30. Electronic Signatures: Authenticated electronic signatures are legally acceptable pursuant to Section 14-16-7 NMSA 1978. The parties agree that this Agreement may be electronically signed and that the electronic signatures appearing on the Agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

SIGNATURES ON NEXT PAGE

Approved By:  Date: 7/6/2022 | 11:25 AM MDT
Name: Lawrence Rael Title: Chief Administrative Officer

Exhibit A

P.A.T.H. Substance Use Treatment Subsidy Voucher Program

Client information and associated data that is created, documented, and maintained as part of the P.A.T.H. voucher system resides at both the contracted agencies and with the City. Providers have access to confidential information about their own clients only. City staff are the first source of information for questions regarding the use of client data, the P.A.T.H. Voucher Program, or about computer-related issues in general.

Payments to providers are calculated on a service-by-service basis, using a standardized rate schedule (See current Voucher Clinical Services Specifications for the City of Albuquerque Voucher System, as revised). The services allowable are determined by the type of voucher that has been issued by the Contractor and by the standardized rate schedule. Individual services are restricted to defined minimum and maximum time limits. Some services, such as case management, have other restrictions imposed on them. The Voucher Clinical Services Specifications for the City of Albuquerque P.A.T.H. Voucher Program, as revised, provides a detailed account of the voucher and service types, rate schedule and restrictions that are in effect for the voucher program.

Process Description

I. Issuance and authorization of treatment vouchers

The identification of clients who are eligible for treatment subsidies is part of the standard process of P.A.T.H. agencies. Eligibility is defined as clients who are;

- Actively be in need of substance use disorder treatment (defined as having used substances in the last two years, or used substances in the last two years if incarcerated)
- Not currently receiving Medicaid full benefits
- Not receiving substance use treatment through other funding sources
- Considered very low income according to the federal HUD guidelines (see below)
- Be a resident of the City of Albuquerque/Bernalillo County
- If a client has commercial insurance that covers the cost of Behavioral Health Services, they are eligible for a voucher IF the deductible is greater than \$2,500.00 OR the co-pay is \$35 or higher, and they meet other established criteria above.

Clients who are determined to meet the eligibility criteria for subsidies will then need to have a biopsychosocial assessment conducted to determine need for and level of treatment, by an appropriately licensed counselor. Agencies can utilize the Addictions Severity Assessment provided by the City, or utilize another biopsychosocial assessment that has the following components:

Vouchers are created using the following information:

- A. General Information: Provide a couple of sentences summarizing the intake information such as referral source and reason, age and ethnicity, etc.

- B. Medical: Summarize the information obtained in this area and highlight what might have significance in the development of the addiction or could impact treatment. Identify any possible case management needs in this domain.
- C. Employment/Education: Summarize the information obtained in this area and address how this might contribute to the client's current problems and what he needs to assist in or support his/her recovery. For example, lack of schooling and its impact on ability to obtain employment. If special education, what was the eligibility and how might this impact work or treatment.
- D. Legal: Address most serious current charges and clarify circumstances. For example, if there is a DV charge, describe the circumstances.
- E. Drugs and Alcohol: Summarize the client's patterns of drug/alcohol use over time, including how and why the problems began. Describe any triggers to use, and client's readiness for treatment. If prior treatment, describe the client's experience and their level of success, including when they were in treatment and what type of treatment. Include information about why the client began using substances again.
- F. Family/Social: Describe the family background and how has that impacted the client's development of strengths or limitations. Include the quality of current relationships with both family and social, and the potential impact of those relationships on treatment. List any persons available to participate in and who is in support of the client's treatment. Provide any details about any reported use or neglect disclosed by the client. Describe any areas of their life where they do not feel safe.
- G. Psychiatric: Summarize the information from the section and address the client's overall mental health issues. Include how the client has the client dealt with depression, anxiety or anger in the past. If PTSD is an issue, describe how that developed. Include any problems in this domain impact treatment. Discuss any details about lifetime of trauma and use. If any Suicidal or homicidal ideations, explain. Discuss client's experience in prior mental health treatment. If currently or historically using psychotropic medication, discuss effectiveness.
- H. Summary and Diagnosis: Detail a brief summary of how and why the client was referred and their current living situation. Briefly summarizing the above domains. Summarize any case management needs that were identified. Take all the information/facts gathered and assess why the client is seeking treatment, and their motivation for treatment. This includes an assessment of the predominant treatment needs, and your evaluation of client's current biopsychosocial health. Use your clinical skills to summarize and assess. End with a substance use diagnosis and justification for an approved level of care and any other recommendations that you might have.
- I. The level of care detailed in the summary and disposition will be reported to the City via email. Upon reporting to the City, the following: Client name, level of treatment indicated by assessment, date of assessment, agency name, and confirmation that the client meets the eligibility criteria, a treatment voucher, with an active life of one-year (365 days) will be approved by the City and is available for invoicing in accordance with this Agreement.

II. Submission of charges for payment against treatment vouchers

*The creation of a treatment voucher is not a guarantee of payment for services up to the full voucher value. It is only a commitment on the part of the City of Albuquerque to pay for services up to that maximum while funding is available and the client remains eligible in accordance with the pre-screening requirements. If at any point during the fiscal year funds for that year – or for the current quarter, if the fund is allocated quarterly – are exhausted, all subsidies will end for that year or quarter, *irrespective of the existence of vouchers that still retain value.* When the next fiscal period begins, whether a year or a quarter, and new money is allocated to the funding pool, vouchers that have not expired and are not fully expended will again be chargeable for services, but only for services rendered after the beginning of the new fiscal period.*

In order to receive payment, the Contractor must first submit an invoice to the City. The first Service Period will be from July 1, 2022, through July 9, 2022, and subsequent Service Periods will be for a two (2) week period (Sunday through Saturday), with exceptions noted on Exhibit A, Attachment 2, P.A.T.H. Substance Use Treatment - Provider Network Voucher Program 2022 – 2023 Service Invoicing Schedule, which is attached hereto and incorporated herein.

- A. The contractor will be required to submit a Request for Reimbursement (Excel Spreadsheet) every two (2) weeks according to the P.A.T.H. Substance Use Treatment - Provider Network Voucher Program 2022 – 2023 Service Invoicing Schedule. The contractor will be required to enter the following information on the Request for Reimbursement:
 - i) Agency name
 - ii) Agency full address
 - iii) Agency POR #
 - iv) Billing period
 - v) Invoice date
 - vi) Client number
 - vii) Date of service, must fall between the effective and expiration dates of the voucher
 - viii) Service type, must be one of those authorized for the particular type of voucher that was issued
 - ix) Time of service
 - x) Number of Service Units (The duration of the service must fall within the limits specified for that service type)
 - xi) Total charges—based on the current Fee Schedule. For those agencies that are For Profit, the Excel Spreadsheet will automatically total Gross receipt taxes based on the current tax rate. The value of the service must be less than or equal to the remaining value of the voucher.
 - xii) Signature of authorized representative of the agency indicating approval of the invoice.

- B. The Contractor must enter the Services during the correct time period in order to be paid. Pre-billing and back-billing are not allowed. Services must have occurred between the start and end of the current Service Period to be paid. Services provided prior to the Service Period cannot be entered and will not be paid.

- C. Payment is conditional on availability of funding. As Services are submitted, the amount of available funding is reduced. If Services are not accepted by the City, payment will not be made.
- D. Payments shall be made to the Contractor no more often than every two (2) weeks, but no less frequently than monthly, upon receipt by the City of properly documented requisitions for payment as determined by the budgetary and fiscal guidelines of the City and on the condition that the Contractor has accomplished the Services to the satisfaction to the City.

IMPORTANT NOTE: Any service accepted by the City will be compensated. The total funds available for subsidies are reduced as services are paid to the contractor. In addition to the aforementioned items, it is important to note that the City only allows submission of services that meet the following criteria:

- A. The service has already occurred before billing the City. **(NO PRE-BILLING);** and
- B. The service must have occurred between the start and the end of the current two-week invoicing period **(NO BACKBILLING).**

III. Invoicing and payment of services

Invoices for services covered by treatment vouchers must be generated every two weeks and submitted to the City for payment. For current Fiscal Year invoice cycle, please refer to Attachment 2. The process of submitting services is:

- A. Services performed on or after the start day for the invoice period are not invoiced until the next invoice period. **For example:**
 - i.) July 10, 2022 ends an invoice period. July 11, 2022 starts the next one.
 - ii.) July 15, 2022 is the day on which invoices are submitted.
 - iii.) A service rendered on July 9th or 10th would be included on the invoice ending July 10, 2022.
- B. It is the responsibility of the contractor to ensure that all required information is included on the Request for Reimbursement form, and also that the Request for Reimbursement is submitted on time. The contractor is to submit their approved Request for Reimbursement via email to the assigned program specialist, and copy the Community Outreach Coordinator and Division Manager. The City will then follow their internal process to complete payment. The City deposits the invoiced amounts directly into the contractor's bank account for entities who have selected this designation.
- C. The City may conduct a minimum of two billing reviews per year of each P.A.T.H. Voucher Treatment Provider. All undocumented/incorrectly documented, but paid services must be reimbursed to the City. All back-billed services will be considered "undocumented" services and must be reimbursed to the City.

IV. Voucher closure/expiration and subsidy shortfalls

Vouchers are in effect for 365 days from the date of assessment, when client eligibility is determined. If at the end of this period all subsidy funds have not been expended and the client is still in treatment, a client may – on a case-by-case basis – receive a time extension on the voucher’s expiration date. No request for additional funding will be accepted or approved during the course of the client’s treatment unless as stated below. If the client presents to the agency for another assessment *subsequent to* the expiration of a previous voucher, voucher eligibility may be reconsidered, but this will also be on a case-by-case basis.

One way in which a client can be made eligible for more money than was originally granted is for the client’s voucher to be upgraded to a type that includes a greater variety of services and a higher total value. Thus, a client who initially received an *Outpatient (I)* voucher, valued at \$5,200, might subsequently be deemed in need of more intensive services, and the voucher upgraded to *Outpatient with Intensive Services (II.1)*, worth \$6,800. This latter value – \$6,800 – is the maximum value of a voucher which an individual client can receive within any treatment episode, and it is available **only** with a voucher that includes intensive services. The upgrade process requires a clinical review of the client’s circumstances by either City staff or a designated Utilization Review person/board, and documentation in the client’s chart as to the rationale for the upgrade and the outcome of the process, utilizing the Voucher Modification Form (see Attachment 5). If a treatment provider requests an upgrade to a clients’ Level of Service, and the request is approved by the City, the provider **must** increase the amount of services provided to the client to remain compliant with the service mix detailed in the Minimum Standards.

A second way additional dollars can be added to the voucher is by requesting a time extension of six months or by adding additional funds to the voucher. The criteria for requesting a time extension is if the client continues to demonstrate a need for treatment, there are voucher funds remaining, and the voucher is expiring in the next month or less. The criteria for requesting additional dollars be added to the voucher is that there is more than a month left in the timeframe of the voucher, the client is actively participating in treatment, and requires additional funding to complete treatment. This process is done by submitting a voucher modification form (see Attachment 5) completed by the client’s therapist, and approved by the agency’s Clinical Supervisor. The voucher modification form is then emailed to the Clinical Consultant to the City of Albuquerque. Once approved by the Clinical Consultant, the voucher modification form is then emailed to City Staff for approval. Once approved by all required staff, the Program Specialist will email a copy to the agency for their records.

The only circumstances that would necessitate the closure of a voucher prior to its 365-day life are:

- A. A change in the client’s residency, moving the client outside of the of Albuquerque Metropolitan area.
- B. The death of the client.
- C. A change to the treatment provider system by the City of Albuquerque.

Providers are responsible for discharging the client from the P.A.T.H. Voucher Program when any of the above situations occurs. In addition, providers are required by their contracts with the City to communicate discharge/separation information from the P.A.T.H. Program. Failure to

provide this information constitutes non-compliance with the contract and could be grounds for contract termination. Clients cannot receive subsidies for the same type of treatment from more than one provider at a time, so separation information is necessary if a client is being re-referred and the new provider is expecting the client to be subsidized. Separation information is also essential if the City and the provider network are to accomplish the goal of capturing accurate descriptive data – length of stay, treatment completion rates, circumstances at discharge, etc. – regarding the substance use treatment setting in Albuquerque.

Quarterly Progress and Discharge information will be collected and reported to the City in the Client Progress Record (See Attachment 3 for instructions).

Because the P.A.T.H. Voucher Program operates with limited money while the need for subsidized treatment is great, it is possible that each year's subsidy fund may not cover all services provided to all qualified clients. In order to reduce the impact of funding shortfalls on providers, subsidy funds will be allocated on a quarterly basis during the fiscal year (July 1 to June 30), one-fourth being made available July 1st, one-fourth added in on October 1st, and so on. If the quarterly allotment is exhausted prior to the end of the quarter, **service subsidies will stop** until the new quarter begins and/or a new allotment is added. At that point services rendered **after the beginning of the new quarter** can be entered and subsidized. Services that the P.A.T.H. Voucher Program does not accept at the end of any quarter will not be subsidized. This approach to fund allocation may produce a brief period of non-payment at the end of each quarter, but it will guarantee that funding is available in all four quarters, and that there is no long, disruptive interruption of subsidies in the last months of the fiscal year.

CITY OF ALBUQUERQUE
Income Limit Reference

United States Department of Housing and Urban Development
2022 Income Thresholds Albuquerque, New Mexico

ADJUSTED INCOME LIMITS

<https://www.cabq.gov/family/documents/publications/hud-income-rent-limits.pdf/view>

Program	1 Person	2 Person	3 Person	4 Person	5 Person	6 Person	7 Person	8 Person
30% of AMI	15,900	18,150	20,400	22,650	24,500	26,300	28,100	29,900
50% of AMI	26,450	30,200	34,000	37,750	40,800	43,800	46,850	49,850
60% of AMI	31,740	36,240	40,800	45,300	48,960	52,560	56,220	59,820
80% of AMI	42,300	48,350	54,400	60,400	65,250	70,100	74,900	79,750
Area Median Income (AMI)	52,900	60,400	68,000	75,500	81,600	87,600	93,700	99,700

City of Albuquerque
P.A.T.H. Substance Use Treatment - Provider Network Voucher Program
2022–2023 Service Invoicing Schedule

QUARTER 1 Service Period	QUARTER 1 Last Date to Submit Invoice to City
July 1 – 9, 2022	July 15, 2022
July 10 – 23, 2022	July 29, 2022
July 24 – August 6, 2022	August 12, 2022
August 7 – 20, 2022	August 26, 2022
August 21 – September 3, 2022	September 9, 2022
September 4 – 17, 2022	September 23, 2022
September 18 – October 1, 2022	October 7, 2022
QUARTER 2 Service Period	QUARTER 2 Last Date to Submit Invoice to City
October 2 – 15, 2022	October 21, 2022
October 16 – 29, 2022	November 4, 2022
October 30– November 12, 2022	November 18, 2022
November 13 – 26, 2022	December 2, 2022
November 27 – December 10, 2022	December 16, 2022
December 11 – December 24, 2022	December 30, 2022
December 25, 2022 – January 7, 2023	January 13, 2023
QUARTER 3 Service Period	QUARTER 3 Last Date to Submit Invoice to City
January 8 – 21, 2023	January 27, 2023
January 22 – February 4, 2023	February 10, 2023
February 5 – 18, 2023	February 24, 2023
February 19 – March 4, 2023	March 10, 2023
March 5 – 18, 2023	March 24, 2023
March 19 – April 1, 2023	April 7, 2023
QUARTER 4 Service Period	QUARTER 4 Last Date to Submit Invoice to City
April 2 – 15, 2023	April 21, 2023
April 16 – April 29, 2023	May 5, 2023
April 30 - May 13, 2023	May 19, 2023
May 14 – 27, 2023	June 2, 2023
May 28 – June 10, 2023	June 16, 2023
June 11 – 24, 2023	June 30, 2023
June 25 – June 30, 2023	July 7, 2023

The City of Albuquerque collects data to determine the effectiveness of its voucher-based substance use program. The City has developed a Client Progress Record that includes information on discharge which collects information on clients' outcomes using several indicators, including: Medical History, Employment, Financial and Educational information, Substance Use, Legal Status to include arrests/criminal justice involvement, Housing, Family and Interpersonal Information, and Psychiatric status. Due to the manual process, the initial data must be completed at the time of client's entry into the P.A.T.H Voucher Program. Treatment provider agencies will be required to collect outcomes data quarterly and at a client's Discharge date from the program. The client's progress must be completed and reported quarterly and at discharge.

The forms should be completed by treatment staff with the client present, as part of an INTAKE session, a treatment session QUARTERLY, and at DISCHARGE. If a client has completed his/her treatment program, the Client Progress Record should be completed with the client present to obtain the best information possible from the client when the client is being discharged. However, if a client is being discharged because: (1) the client never showed up for services, (2) dropped out, (3) is incarcerated, or (4) is deceased, the client's assigned counselor must complete the Client Progress Record.

1. The Client Progress Record (Outcomes and Discharge Reports) will need to be completed and reported on the Request for Reimbursement.
2. The form should be completed and entered within two weeks of the treatment plan updates and within two weeks of the end of the completed discharge.
3. A fee of \$8.00 will be paid for each Discharge and Outcomes Report Form.

Discharge Information (completed at time of discharge in addition to items referenced above)

1. Notes should list therapist name at the provider agency.
2. At discharge, choose the appropriate reason, and indicate who the report is completed by;
 - a. Treatment Staff with Client, with the treatment staff asking the questions, as part of a treatment session, with the client present. (A maximum of 2 units of Individual Counseling can be billed to complete the form, in addition to the \$8.00 allocated to complete and submit the discharge and outcomes data.)
 - b. Treatment Staff Only, if the form is completed by treatment staff without the client being present. This would occur only when the agency has lost contact with the client for 30 days, or more and the client must be discharged. (A maximum of \$8.00 has been allocated to submit the discharge and outcomes data.)
3. Date the client was discharged from your program. The Discharge and Outcomes Report Form must be completed within 30 days of the last face-to-face service provided or within 30 days from the last face-to-face client contact if the agency has lost contact with the client. The Discharge and Outcomes Report Form should also be completed when the client is leaving the P.A.T.H. Program because of treatment completion.

4. Type of Discharge. Complete only at discharge. List the most appropriate reason that describes the reason for the discharge:
- a. Completed treatment. The client has successfully met required treatment goals and treatment sessions (as specified in the treatment plan), has a relapse prevention plan and/or aftercare plan, if applicable. The client may have been advised to continue in aftercare on a self-pay or other payment basis.
 - b. Court ordered treatment sessions completed. The client has completed the required number of sessions (as per court order) and has met required court mandated treatment goals. The client has been advised to continue in treatment as further treatment is needed and voucher funds have not been expended.
 - c. Voucher funds expended. The client has expended the voucher funds available and is unable to self-pay even with a sliding fee scale. The agency has completed a discharge summary.
 - d. Voucher Funds Expended/Client Still in Treatment. The client has expended the voucher funds available, and the agency has completed a discharge summary, but the client continues to participate in treatment services and/or aftercare services.
 - e. Terminated Services – Dropped Out. The client has voluntarily dropped out of treatment against the recommendation of the treatment counselor, and the agency has completed a discharge summary.
 - f. Terminated Services – Lost Contact. The agency has lost contact with the client and has documented efforts to re-engage the client through phone calls or mailings and the agency has completed a discharge summary.
 - g. Client moved out of area. Clients must be residents of the City of Albuquerque. The client has moved out of Albuquerque and no longer qualifies for services. The agency has completed a discharge summary.
 - h. Non-compliance with agency policies. The agency has discharged a client due to non-compliance with agency policies regarding treatment or program rules (threats or violence against staff, other clients, etc.), which have been documented within a completed discharge summary.
 - i. Administrative Discharge. The client has been administratively discharged as the client has not accessed services for 30 days and the agency has not completed a discharge summary. The agency will be asked to complete a discharge summary.
 - j. Incarcerated. The client is in jail or prison, and the agency has completed a discharge summary.
 - k. Deceased. The client has died, and the agency has completed a discharge summary.
 - l. Client received alternative funding. The client has secured funding for treatment services other than through the City of Albuquerque and client has decided to voluntarily leave treatment through the City's system. An example is a client has received funds (Medicare, Medicaid) to enter an in-patient treatment program. The agency has completed a discharge summary.
 - m. Client changed program or provider. The client has decided to seek treatment through another agency in the City's voucher-based system other than the agency he/she was initially referred to. The original agency must release the client by completing a discharge summary form.

5. Clinical Recommendations. Complete only at discharge. The client:
 - a. Needs further treatment services? Indicate the appropriate answer: “Yes”, “No”, “Not Applicable”, or “Unknown”. If “Yes” please provide a brief description of the services needed.
 - b. Needs additional recovery support services? Indicate the appropriate answer: “Yes”, “No”, “Not Applicable”, or “Unknown”. If “Yes”, please provide a brief description of the recovery support services needed.
 - c. Is participating in an aftercare program? (Aftercare participation means a client attends scheduled sessions following a formal discharge from treatment for the purpose of relapse prevention.) Indicate the appropriate answer: “Yes”, “No”, “Not Applicable”, or “Unknown”. If the answer is “Yes,” please provide a brief description of the aftercare program.

6. Client Progress Update – indicate the client’s status for each outcome indicator.
 - a. Arrest History/Criminal Justice Involvement: Check if the client is on probation at the time the report is completed.
 - b. Education: check if the client has taken any vocation or educational training the last 90 days. This would include enrollment for job skills training at places such as the State Department of Vocational Rehabilitation or attending technical-vocational programs offered at educational institutions such as Central New Mexico Community College.
 - c. Employment: Type in the number of days employed in the last 90 days, regardless of the type of employment.
 - d. Primary Health Care: Check if the client has a primary health care provider and access to health care services through a clinic or primary health care setting and does not rely on hospital emergency room services; leave blank if the client does not have a primary care provider and access to health care services through a clinic or primary health care setting and utilizes the hospital emergency room services for primary health care or if unknown.
 - e. Social Problems: Type in how many times in the past 30 days the client has experienced Social Problems.
 - f. Insurance: Check if the client has had a change in their insurance coverage in the last 90 days.
 - g. Controlled environment: Type in the number of days a client has been in a controlled environment, and indicate which type environment(s) the client has resided.
 - h. Living Conditions: Select the most appropriate Living Conditions status for this client at the time of the form is completed.
 - i. Social Determinants of Health. The City is collecting information regarding Social Determinants of Health (SDOH) to provide a uniform means to collect information through City-funded social service contracts on the unmet needs encountered by service customers. This screening tool uses a modified portion of the questions from the AHC HRSN Screening Tool issued by the Centers for Medicare and Medicaid Services (CMS), and includes suggested City-added text to improve clarity. Complete the SDOH form in accordance with instructions and submit with the invoice during which the quarterly progress report is completed.

CLIENT PROGRESS UPDATE AND/OR DISCHARGE REPORT

CLIENT AND PROGRAM INFORMATION

Client Name	Client ID #	Level of Care
Name of Treatment Provider	Name of Primary Counselor	Date of Admission
Date of Last Contact	Report Completed By (Check one below) <input type="checkbox"/> Treatment Staff with Client <input type="checkbox"/> Treatment Staff Only	

DISCHARGE STATUS

Date of Discharge ____/____/____ (MM/DD/YY) Identify the type of discharge (check one only). <input type="checkbox"/> a. Completed treatment <input type="checkbox"/> b. Court ordered treatment sessions completed <input type="checkbox"/> c. Voucher funds expended <input type="checkbox"/> d. Voucher funds expended / Client still in treatment <input type="checkbox"/> e. Terminated services - dropped out <input type="checkbox"/> f. Terminated services - lost contact <input type="checkbox"/> g. Client moved out of area <input type="checkbox"/> h. Non-compliance w/agency policies <input type="checkbox"/> i. Administrative discharge <input type="checkbox"/> j. Incarcerated <input type="checkbox"/> k. Deceased <input type="checkbox"/> l. Client received alternative funding <input type="checkbox"/> m. Client changed program or provider	Clinical Recommendations - The client has a need: (Please use: Yes, No, An Amount, or a Check Mark as Indicated) <input type="checkbox"/> a. For further treatment services? If yes, describe _____ <input type="checkbox"/> b. For additional recovery support services? If yes, describe _____ <input type="checkbox"/> c. The client is participating in an aftercare program? ("Aftercare" means a client attends scheduled sessions following a formal discharge from treatment for the purpose of relapse prevention.) If yes, describe _____
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CLIENT PROGRESS UPDATE (Due every 90 days with Treatment Plan Update)

Indicate the client's status for each outcome indicator. (Please use: Yes, No, An Amount, or a Check Mark as Indicated)	
Arrest History/Criminal Justice Involvement <input type="checkbox"/> On Probation Education Status <input type="checkbox"/> Have you taken any vocational or educational training in the last 90 days? Employment Status <input type="checkbox"/> Number of days in Last 90 days Employed Primary Health Care <input type="checkbox"/> Client has access to primary health care services <input type="checkbox"/> How many times in the past 30 days has client experienced Social Problems <input type="checkbox"/> Has the client had a change in insurance coverage in the past 90 days? <input type="checkbox"/> Number of days in past 90 days has client been in a Controlled Environment (indicate which below) Jail/Prison <input type="checkbox"/> Halfway House Alcohol or Drug Tx. <input type="checkbox"/> Residential Tx. Medical Tx. <input type="checkbox"/> Other _____ Psychiatric Tx.	Living Conditions Status - Client is living <input type="checkbox"/> a. With family <input type="checkbox"/> b. With sexual partner alone <input type="checkbox"/> c. With children alone <input type="checkbox"/> d. With parents <input type="checkbox"/> e. Alone <input type="checkbox"/> f. With sexual partner and children <input type="checkbox"/> g. With friends <input type="checkbox"/> h. A controlled environment <input type="checkbox"/> i. With sexual partner, children & others <input type="checkbox"/> j. No stable environment <input type="checkbox"/> Number of Months in Current Living Situation

CLIENT SIGNATURE _____ DATE _____

PRIMARY COUNSELOR SIGNATURE _____ DATE _____

CLINICAL SUPERVISOR SIGNATURE _____ DATE _____



SOCIAL DETERMINANTS OF HEALTH

Purpose: Provide a uniform means to collect information through City-funded social service contracts on the unmet needs encountered by service customers. Data otherwise not available will be used to inform the City and public on unmet needs that need attention and aggregate progress of city-funded services.

Validity: This screening tool uses a modified portion of the questions from the AHC HRSN Screening Tool issued by the Centers for Medicare and Medicaid Services (CMS)¹, and includes suggested City-added text to improve clarity. Multiple Albuquerque agencies and health providers use the original CMS screening tool, which allows data collected by the City can be compared with a rich local and national dataset. Screening questions are organized in the City of Albuquerque Family and Community Services Outcome categories, all of which contribute to improve public safety.

Instructions: Administer at intake, quarterly and at discharge. Provide the completed form to the City with the biweekly invoices. Any "yes" responses or responses that indicate additional supports are needed requires additional screening and/or referral as appropriate.

Agency Name: _____

Date: _____

Client Number: _____

☐ Intake ☐ Quarterly ☐ Discharge

Client Age: ☐ 18-24 ☐ 25-45 ☐ 46-65 ☐ over 65 Gender: ☐ M ☐ F ☐ Other

Race & Ethnicity

- | | |
|--|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Two or more races |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Hispanic or Latino |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> White alone, not Hispanic or Latino |
| <input type="checkbox"/> Native Hawaiian or Other Pacific Islander | - |

1. Within the past 3 months have you worried that food would run out for you and your family?²

- ☐ Often true
- ☐ Sometimes true
- ☐ Never true
- ☐ N/A - I was in a residential facility the last three months or longer (can include hospital, residential treatment, correctional facility, etc.)
- ☐ Uncomfortable in disclosing at this time

- 2. In the past 3 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? ¹**
- ☐ Yes
- ☐ No
- ☐ N/A - I was in a residential facility the last three months or longer (can include hospital, residential treatment, correctional facility, etc.)
- ☐ Uncomfortable in disclosing at this time
- 3. Has anyone, including family and friends, in the last 3 months, harmed you or threatened you with harm (physically, psychologically, or emotionally, which can include isolation, financial control, sexual abuse, or manipulation)? ²**
- ☐ Yes
- ☐ No
- ☐ Uncomfortable in disclosing at this time
- 4. Do you want help finding or keeping work or a job or with school or training? ³**
For example, finding a job, keeping a job, starting or completing job training or getting a high school diploma, GED or equivalent. Check all that apply.
- ☐ Yes, help finding work
- ☐ Yes, help keeping work
- ☐ Yes, help getting a high school diploma, GED or equivalent
- ☐ Yes, help getting job training
- ☐ I do not need or want help
- ☐ Uncomfortable in disclosing at this time
- 5. In the last 3 months has your use of substances interfered with your daily life? ⁴**
(such as alcohol, non-medical use of drugs)
- ☐ Yes
- ☐ No
- ☐ Uncomfortable in disclosing at this time

¹ Adapted from CMS AHC HRSN Q # 5. National Association of Community Health Centers and Partners, National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. (2017). PRAPARE. <http://www.nachc.org/research-and-data/prapare/>

² Adapted from CMS AHC HRSN Q # 9. Sherin, K. M., Sinacore, J. M., Li, X. Q., Zitter, R. E., & Shakil, A. (1998). HITS: a Short Domestic Violence Screening Tool for Use in a Family Practice Setting. Family Medicine, 30(7), 508-512.

³ Combined CMS questions # 12 and 16. Identifying and Recommending Screening Questions for the Accountable Health Communities Model (2016, July) Technical Expert Panel discussion conducted at the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Baltimore, MD.

⁴ Combined and adapted CMS questions # 21 and 22. United States, U.S. Department of Health and Human Services, National Institutes of Health. (n.d.). Helping Patients Who Drink Too Much: A Clinician's Guide (2005 ed., pp. 1-34).

- 6. Has your mental health problems interfered with functioning in your daily life in the past 3 months? ⁵** (For instance, feeling depressed, hopeless, disoriented, unmotivated, sleeping longer, crying uncontrollably, loss of appetite or weight loss) *If a client discloses suicidal ideation, the agency has the obligation to provide appropriate follow-up.
- ☐ Yes
- ☐ No
- ☐ Uncomfortable in disclosing at this time
- 7. What prevents you from getting childcare for your children if you need it? ⁶**
- ☐ N/A (no children or do not need childcare)
- ☐ Cannot afford childcare
- ☐ Transportation
- ☐ Do not know where to access childcare
- ☐ Do not qualify for childcare
- ☐ Uncomfortable in disclosing at this time
- 8. In the past 3 months, have you used the emergency room instead of going to a primary care doctor or clinic due to lack of insurance or affordability? ⁷**
- ☐ Yes
- ☐ No
- ☐ N/A - I was in a residential facility the last three months or longer (can include hospital, residential treatment, correctional facility, etc.)
- ☐ Uncomfortable in disclosing at this time
- 9. In the past 3 months has the electric, gas, oil, or water company threatened or shut off services in your home? ⁸**
- ☐ Yes
- ☐ No
- ☐ N/A - I was in a residential facility the last three months or longer (can include hospital, residential treatment, correctional facility, etc.)
- ☐ Uncomfortable in disclosing at this time

⁵ Adapted from CMS question #23 a. and b. Kroenke, K., Spitzer, R. L., & Williams, J. B. (2003). The Patient Health Questionnaire-2: validity of a two-item depression screener. *Medical Care*, 41(11), 1284-1292.

⁶ Adapted from *WellRx Toolkit*, University of New Mexico Office for Community Health

⁷ Added by the City of Albuquerque, Department of Family and Community Services as an indicator of health needs.

⁸ Adapted from CMS AHC HRSN Q # 6: Cook, J. T., Frank, D. A., Casey, P. H., Rose-Jacobs, R., Black, M. M., Chilton, M., Cutts, D. B. (2008). A Brief Indicator of Household Energy Security: Associations with Food Security, Child Health, and Child Development in US Infants and Toddlers. *Pediatrics*, 122(4), 867-875. doi:10.1542/peds.2008-0286

SDOH Screening Tool

ASK ONLY IF APPLICABLE:

10. Is language a barrier to access services to meet the needs we just discussed? ⁹

- ☐ Yes
- ☐ No
- ☐ Uncomfortable in disclosing at this time

If yes, what is your preferred language for accessing services? _____

⁹ Added in response to feedback from social service agency.

Voucher Modification Form

- Copy new Program Specialist who will notify agency of approval.
- Ensure Release of Information has been completed and maintained in client file.
- Provide Discharge Summary/Transfer Summary to receiving Agency.
- Provide Addiction Severity Assessment (ASA) to receiving Agency.

Date Client Last Seen:

Name of agency client is being transferred to

Assigned Therapist & Clinical Supervisor – Provide justification for change, include information on gaps in treatment:

<div>Printed Name of Therapist w/ Credentials</div>	<div>Therapist Signature</div>	<div>Date</div>
<div>Printed Name of Clinical Supervisor w/ Credentials</div>	<div>Clinical Supervisor Signature</div>	<div>Date</div>

Clinical Consultant – Disposition and Comments:

<div>Clinical Consultant Signature and Credentials</div>	<div>Date</div>
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Program Specialist – City Comments:

<div>Program Specialist</div>	<div>Date</div>
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City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division

P.A.T.H.
Providing Addiction Treatment and Healing
Substance Use Treatment Provider Network
FY-2023 Application Packet

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**City of Albuquerque
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PROVIDER APPLICATION INSTRUCTIONS

Purpose

The Behavioral Health and Wellness Division is accepting applications to become a City of Albuquerque Substance Use Treatment Provider, to be part of The P.A.T.H., for FY-2023. It is the intent of the City to continue the development of a Substance Use Treatment Provider Network which is able to provide high quality, ethical, comprehensive, and evidence-based substance use treatment. The City desires to develop a full continuum of treatment services and ensure that all agencies are clinically appropriate and culturally relevant to meet the needs of those in treatment.

The Behavioral Health and Wellness Division has an open application process to become a member of the City's Substance Use Treatment Provider Network. Only those applicants scoring 160 points or above will be considered for a contract. Agencies currently contracting with the City to provide substance use treatment who score less than 160 will not be eligible to reapply until the next fiscal year (FY-2023), and will need to submit a plan of action to their assigned program specialist detailing how current clients will be transitioned to other voucher agencies to continue their treatment beyond June 30, 2022. Agencies who score less than 160 and are not currently contracting with the City, may resubmit an application before January 31st of Fiscal Year 2023 to be reconsidered for funding. The Department reserves the right to refuse to proceed with the development of a contract at any time if it is in the best interest or convenience of the City.

Please Note:

Applications that received a score of 180 or above in FY- 2022, have had acceptable monitoring visits, at the discretion of the City, need only complete the re-application packet for FY-2023. The re-application packet will be emailed to you by your program specialist.

The City will not issue a contract for FY-2023 to any agency with outstanding debt(s) to the City.

Application Forms and Instructions

There is one application for both Adult and Adolescent substance use treatment services. Please mark the appropriate box on the application. In developing your application, be sure to answer **all** questions with **complete** and **thorough** responses.

Applications must be in 12-point font. Each narrative response should be concise, complete, and must not exceed **three (3) single sided pages** in length. Do not delete questions from the application. Provide your answers below the question. Appendices or non-required attachments including letters of endorsement, agency brochures, or news clips may be included if copied onto 8 1/2" x 11" paper.

Applications will be submitted electronically, via email.

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Application Review

Applications will be reviewed by the Behavioral Health and Wellness Division based on the criteria in the table below. A Technical Review will be conducted prior to scoring: Incomplete applications or applications missing documentation may be deemed nonresponsive. A minimum score of 160 is required to be eligible to receive a contract for FY-2023.

Criteria	Maximum Score: Current Providers	Maximum Score: New Providers
Past Performance	20	N/A
Clinical Supervision/Staff Credentials	20	25
Case Management	25	25
Mental Health Services	10	10
Vouchered Services	15	15
Discharge Planning	10	10
After-Care	10	10
ASAM Criteria	20	20
Service Mix	25	25
Treatment Offered and Recovery Philosophy	45	60

Provider Application Guides

Please refer to the ***Albuquerque Minimum Standards for Substance Abuse Treatment***, the ***Administrative Requirements for Contracts Awarded under the City of Albuquerque***, and the additional information contained within this FY-2023 Application Packet prior to developing your Applications' responses.

Submitting Your Application

Submit one complete original application, including all required attachments, via email to Jeanné Padilla, Program Specialist, at jcpadilla@cabq.gov. Label the submission as **Substance Use Treatment Provider Network Application – FY-2023**. Please number and collate. Applications must be submitted to the Behavioral Health and Wellness Division and received no later than **4:00 p.m., Thursday, January 31, 2023. (Earlier submissions are highly recommended)**. Applications received after that date and time will not be accepted for Fiscal Year 2023. Earlier submissions are highly encouraged to allow for adequate time for review, and contract execution. Email Application Package to Jeanné Padilla, Program Specialist at jcpadilla@cabq.gov.

Applications may be posted on the Behavioral Health and Wellness Division website after contracts have been awarded.

City of Albuquerque
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ASAM PATIENT PLACEMENT CRITERIA

LEVEL 0.5 – EARLY INTERVENTION

Early Intervention is an organized service designed to explore and address problems that appear to be related to substance use and to help the individual recognize the harmful consequences of inappropriate substance use. This level is appropriate for individuals who demonstrate problems and risk factors that appear to be related to substance use but do not meet the diagnostic criteria for Substance-Related Disorder as defined in the current *Diagnostic and Statistical Manual of Mental Disorders (DSM)*.

Length of Service

Length of Service at Level 0.5 varies according to: (a) an individual's ability to understand the information provided and use of that information to make behavior changes and avoid problems related to substance use or (b) the appearance of new problems arise that require treatment at another level of care.

Required Support Systems

Level 0.5 requires the following Support Systems:

1. Referral for ongoing treatment of substance use or dependence;
2. Referral for medical, psychological or psychiatric services, including assessment; or,
3. Provide case management and/or referral to other social service agencies.

Staff

Level 0.5 staff are trained and knowledgeable about biopsychosocial dimensions of substance use and dependence, the recognition of substance related disorders, alcohol and other drug education, motivational counseling, and the legal and personal consequences of inappropriate substance use.

Interventions

Interventions at this level can include individual, group or family counseling, as well as planned educational experiences that focus on helping the individual to avoid harmful or inappropriate substance use.

LEVEL I – OUTPATIENT TREATMENT

Level I encompasses organized outpatient treatment services in which Substance Use Treatment professionals, including addiction-licensed physicians, provide professionally directed evaluation, treatment and recovery services. Such services are provided in regularly scheduled sessions of (usually) fewer than nine contact hours a week in accordance with the City's required Service Mix. The services follow a defined set of policies and procedures or clinical protocols.

Level I services are tailored to each client's level of clinical severity and are designed to help the client achieve changes in substance use behaviors. Treatment must address major lifestyle, beliefs, and behavior patterns that have the potential to undermine the goals of treatment or to impair the individual's ability to cope with major life tasks without the non-medical use of substances.

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Level I services are appropriate in several different situations:

- Level I may be the initial level of care for a client whose severity of illness warrants this intensity of treatment. Such a client should be able to complete professionally directed addiction treatment at this level. Level of treatment may change based on (a) an unanticipated event causes a change in his or her level of functioning, leading to a reassessment of the appropriateness of this level of care, or (b) there is recurring evidence of the client's inability to use this level of care (such as repeated episodes of drinking or non-medical drug use even after the treatment plan has been reviewed and revised).
- Level I may represent a "step down" from a more intensive level of care for a client whose progress warrants such a transfer, assuming that he or she meets Level I placement criteria.
- Level I may be used for a client who is in the early stages of change and who is not yet ready to commit to full recovery (Dimension 4 issues). For such a client, placement in a more intensive level of care is apt to lead to increased conflict, passive compliance or even leaving treatment.

The relationship between the severity of illness and the intensity of treatment is more clearly seen in Dimensions 1, 2, and 3. On the other hand, increasing the intensity of services solely because of Dimension 4 issues may be counterproductive. An alternative approach is to use Level I services to engage the resistant individual in treatment. If this approach proves successful, the client may no longer require a higher intensity of service, or may be able to better use such services.

Co-Occurring Mental and Substance Related Disorders

Level I services are appropriate for clients with co-occurring disorders if:

1. The clients' disorders are of *moderate severity* (Dimension 3 is very stable or the client is receiving concurrent mental health monitoring) and clients have responded to more intensive treatment services. The co-occurring disorders have been managed to an extent that addiction treatment services are assessed as potentially beneficial. However, ongoing monitoring of the client's mental status is required.
2. The clients' disorders are of *high severity* (Dimension 4 indicates a high resistance to change, but client is stable in the other Dimensions) and persist but have stabilized to such an extent that integrated mental health and substance use treatment services are assessed and may be beneficial. Clients who have severe and persistent mental illness may not have been able to achieve sobriety or to maintain abstinence for a significant period of time (months); however, they are appropriately placed at Level I because they need engagement strategies and intensive Case Management Services.

Length of Service

Duration of treatment varies with the severity of an individual's substance use and response to treatment.

Required Support Systems

Level I clients require the following support systems:

1. Referral, consultation, or onsite medical, psychiatric, psychological, laboratory and toxicology services. Medical and psychiatric consultation should be available in a time frame appropriate to the severity and urgency of the situation;

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2. Direct affiliation with, or close coordination through referral to, more intensive levels of care and medication management, and
3. Emergency services available by telephone 24 hours a day, 7 days a week.

Staff

Level I treatment providers are staffed by appropriately licensed treatment professionals, who assess and treat substance-related disorders. Staff are able to obtain and interpret information regarding the client's biopsychosocial needs, and are knowledgeable about the biopsychosocial dimensions of alcohol and other drug disorders, including assessment of the client's stage of readiness to change. Staff are capable of monitoring stabilized mental health problems and recognizing any instability of clients with co-occurring mental health problems.

Interventions

Interventions at this level involve appropriate treatment services, which may include individual and group counseling, motivational enhancement, Medication Assisted Treatment (MAT), family counseling, educational groups, occupational and recreational therapy, or psychotherapy. If a client has a co-occurring disorder, the use of psychotropic medication and mental health treatment and the relationship to substance use are addressed as appropriate.

LEVEL II.I - INTENSIVE OUTPATIENT TREATMENT

Intensive outpatient agencies (IOPs) generally provide nine (9) or more hours of structured programming per week, consisting primarily of counseling and education about substance related and mental health problems. The provider facilitates education and treatment services and encourages clients to utilize acquired skills. Providers have the capacity to arrange for medical and psychiatric consultation, psycho-pharmacological consultation, medication management, and 24-hour crisis services. In addition, providers must have the ability to provide case management and/or refer clients to a higher level of care. If the client is stable and requires only monitoring, psychiatric and medical services are addressed through consultation and referral arrangements. Services provided outside the primary agency must be tightly coordinated.

Beyond the essential services, agencies provide psycho-pharmacological assessment and treatment and have the capacity to effectively treat clients who have complex co-occurring disorders.

Co-Occurring Mental and Substance Related Disorders

Level II.I treatment services are appropriate for clients with co-occurring disorders if:

1. The mental health and addiction treatment services are integrated into the intensive outpatient agency.
2. Clients require active mental health services, which should be delivered through Level II.I Dual Diagnosis Capable or Dual Diagnosis Enhanced Programs.

Length of Service

Duration of treatment varies with the severity of the client's illness and his or her response to treatment.

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Required Support Systems

Level II.I requires the following support systems:

1. Referral, consultation, or onsite medical, psychiatric, psychological, laboratory and toxicology services. Medical and psychiatric consultation should be available in a time frame appropriate to the severity and urgency of the situation;
2. Direct affiliation with, or close coordination through referral to, more intensive levels of care and medication management;
3. Emergency services available by telephone 24 hours a day, 7 days a week; and
4. Agencies offering Level II.I services must be staffed to treat clients with co-occurring disorders. Minimum staff licensure requirements are LMHC, LMSW or the equivalent, with the appropriate clinical supervision.

Staff

Level II.I treatment providers are staffed by appropriately licensed treatment professionals, who assess and treat substance related disorders. Staff are able to obtain and interpret information regarding the client's biopsychosocial needs, and are knowledgeable about the biopsychosocial dimensions of alcohol and other drug disorders, including assessment of the client's stage of readiness to change. Staff are capable of and trained to understand the signs and symptoms of mental disorders and to understand and explain the uses of psychotropic medications and their interactions with substance related disorders.

Interventions

Interventions at this level involve appropriate treatment services, which may include individual and group counseling, motivational enhancement, Medication Assisted Treatment (MAT), family counseling, educational groups, occupational and recreational therapy, or psychotherapy. If a client has a co-occurring disorder, the use of psychotropic medication, mental health treatment, and the relationship to substance use are addressed.

REQUIRED SERVICE MIX

EARLY INTERVENTION (LEVEL .5)

Early Intervention/Education level of care is to explore and address problems or risk factors that are related to substance use and to help the client recognize the harmful consequences of inappropriate substance use. Each agency that offers Early Intervention/Education needs to use an established and recognized curriculum. Services are intended to run at least 90 days in length for the average client. Each agency serving clients appropriate for Level .5 should, *at a minimum*, adhere to the following:

1. **Initial Service Plan.** Each client shall have an initial service plan created at the time of intake. The service plan shall be reviewed, signed, and dated by the client, counselor and clinical supervisor. The client must be provided with an Initial Service Plan within 30 calendar days of intake and updated as clinically indicated.

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2. **Early Intervention Session.** Each client shall participate in a minimum of one education group per week, but services are not limited to education groups. If fewer sessions are clinically indicated for a client, this must be justified and documented in the client's record.
3. **Case Management Services.** Each client shall have access, as clinically indicated, to appropriate education, vocational, health, and social services as indicated through the ASA, and Initial Service Plan. If a client is in need of Case Management, as evidenced by the ASA and Initial Service Plan, the agency must provide the non-counseling services on site, or through facilitated referrals. Services and/or facilitated referrals shall be documented in accordance with the Minimum Standards.
4. **Discharge Planning.** The agency must demonstrate Discharge Planning has occurred with clients prior to termination of treatment to put closure on the treatment process and plan for Aftercare support needed to maintain stability and sobriety. Services are provided by the agency after the voucher has expired, including Aftercare, as necessary.
5. **Discharge Summary.** The agency shall complete a Discharge Summary for each client upon discharge from Early Intervention Services.

OUTPATIENT TREATMENT (LEVEL I)

Provide individual, group and/or family counseling for an average period of 90 to 120 days that addresses major lifestyle, beliefs, and behavioral patterns that have the potential to result in addiction or substance use or to impair the individual's ability to cope with major life tasks without the non-medical use of substances. Services are provided in regularly scheduled sessions of usually fewer than nine (9) contact hours per week, but not less than once a week. If fewer or more sessions are clinically indicated for a client, this must be justified and documented in the client's record. Each agency serving clients appropriate for Level I should, *at a minimum*, adhere to the following:

1. **Treatment Plan.** An Individualized Treatment Plan shall be developed within 30 calendar days of intake. The Treatment Plan shall be reviewed and signed by the client, counselor, and clinical supervisor. The Treatment Plan shall be reviewed, updated and signed by client, counselor, and clinical supervisor not less than quarterly.
2. **Counseling Session.** Each client shall participate in a minimum of one individual, group or family counseling session not less than once a week, with a minimum of two individual sessions per month. If fewer sessions are clinically indicated for a client, this must be justified and documented in the client's record.
3. **Case Management Services.** Each client shall have access, as clinically indicated, to appropriate education, vocational, health, and social services as indicated through the ASA, Individualized Treatment Plan, and Case Management assessment and/or service plan. If a client is in need of Case Management, the agency must provide the non-counseling services on site, or through facilitated referrals. Services and/or facilitated referrals shall be documented in accordance with the Minimum Standards.
4. **Discharge Planning.** The agency must demonstrate Discharge Planning has occurred with clients prior to termination of treatment to put closure on the treatment process and plan for Aftercare support needed to maintain stability and sobriety. Services are provided by the agency after the voucher has expired, including Aftercare, as necessary.

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5. **Discharge Summary.** The agency shall complete a Discharge Summary for each client upon discharge from treatment.

INTENSIVE OUTPATIENT TREATMENT AGENCIES (LEVEL II.I)

Provide individual, group and/or family counseling and education about substance-related and mental health problems, with an intensity of nine (9) or more hours of structured programming being offered per week and the client receiving six (6) or more hours of services per week, and a frequency of not less than three (3) times per week for an average of 60 days; once the client reaches the point that Level II.I services are no longer appropriate, the change in service level must be documented in the client's record. Level II.I services have the capacity to arrange for medical and psychiatric consultation, psychopharmacological consultation, medication management, and 24-hour crisis services. The client's needs for psychiatric and medical services are addressed through consultation and referral arrangements if the client is stable and requires only maintenance monitoring. Level II.I agencies must have licensed mental health clinicians on staff or contract to see Level II.I clients. If fewer or more sessions are clinically indicated for a client, this must be justified and documented in the client record.

1. **Staffing.** Agencies offering Level II.1 services must be staffed to treat clients with co-occurring disorders. Minimum staff licensure requirements are LMHC, LMSW or the equivalent, with the appropriate clinical supervision.
2. **Treatment Plan.** An individualized Treatment Plan shall be developed within 30 calendar days of admission. For Level II.1 clients the treatment plan shall be reviewed, and signed, by the client, counselor, and clinical supervisor. The Treatment Plan shall be reviewed, updated and signed by the counselor, client and clinical supervisor not less than quarterly.
3. **Counseling Session.** Each client shall participate in a minimum of one individual, group or family Counseling Session three times per week, with a minimum of one (1) individual session per week, and two (2) group sessions per week. If fewer sessions are clinically indicated for a client, this must be justified and documented in the client record.
4. **Case Management Services.** Each client shall have access, as clinically indicated, to appropriate education, vocational, health, and social services as indicated through the ASA, Individualized Treatment Plan, and Case Management assessment and/or service plan. If a client is in need of Case Management, the agency must provide the non-counseling services on site, or through facilitated referrals. Services and/or facilitated referrals shall be documented in accordance with the Minimum Standards.
5. **Discharge Planning.** The agency must demonstrate Discharge Planning has occurred with clients prior to termination of treatment to put closure on the treatment process and plan for Aftercare support needed to maintain stability and sobriety. Services are provided by the agency after the voucher has expired, including Aftercare, as necessary.
6. **Discharge Summary.** The agency shall complete a Discharge Summary for each client upon discharge from treatment.

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APPLICATION CHECKLIST

Agency Name: Albuquerque Health Services LLC dba/Albuquerque Behavioral Health

Submit this completed checklist with the Application. If you are not submitting all items on this checklist, indicate "N/A" on the line next to the number. **All lines must be completed.**

- ☒ 1. Signed Application Summary and Certification Form.
- ☒ 2. One original Application and applicable appendix.
- ☒ 3. Insurance Waiver if applicable.
- ☒ 4. Registration Certificate from the New Mexico Taxation and Revenue Department or, proof of an exemption from payment of Federal Income Tax pursuant to the Internal Revenue Code of 1954 [26 U.S.C. Section 501(c)(3)] must be included in the Application.
- ☒ 5. Copies of all applicable business licenses including, but not limited to, current City of Albuquerque Business Registration license, etc. (non-profits are not required to submit a City business license)
- ☒ 6. Verification of Substance Use licensure for all current clinical staff/contractors in compliance with the State of New Mexico Substance Use Counselor Act, chapter 61, Laws of 1996, HB 790: Article 9A of the New Mexico Counseling and Therapy Practice Act: section 61-9A-14.2 Substance Use Intern, requirements for licensure; 61-9A-14.3 Alcohol and drug use counselor, requirements for licensure; and 61-9A-16 Temporary licensure.
- NA ☐ 7. A letter of assurance regarding current compliance with all applicable rules and regulations of the Americans with Disabilities Act of 1990, PL 101-336 (42 U.S.C. Section 12101, et seq.) See <http://www.ada.gov> and <http://www.access-board.gov> and Section 504 of the Rehabilitation Act (29 U.S.C. Section 794) <https://www.hhs.gov/sites/default/files/knowyourrights504adafactsheet.pdf> for additional information.
- NA ☐ 8. Certification of Non-Profit Incorporation from IRS, if applicable.
- NA ☐ 9. Articles of Incorporation.
- NA ☐ 10. Current By-laws.
- NA ☐ 11. List of Current Board Members (Non-profit and government agencies only).

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- ☒ 12. Organization Chart.
- NA ☐ 13. Accounting Policies and Procedures. Clearly identify agency's billing and filing procedures.
- ☒ 14. Personnel Policies and Procedures.
- ☒ 15. Operating Standards/Program Policies and Procedures.
- ☐ NA ☐ 16. Conflict of Interest Statement (Non-Profit Only).
- ☒ 17. Certificate of Good Standing, as applicable.
- ☒ 18. HIPAA Compliant Confidentiality Policies.
- ☒ 19. Completed W-9. See <http://www.cabq.gov/dfa/oneservices/modified-w9-supplier-form>.
- ☒ 20. Drug-Free Workplace Statement. Attached.
- ☒ 21. Copies of clinical supervisor's workshop attendance as required by State Regulations. See 16.27.19.9(B) at <http://www.rld.state.nm.us/uploads/files/Counseling%20Rules%20and%20Statutes.pdf> for additional information.
- ☒ 22. Copy of Clinical Supervision Policy.
- ☒ 23. Signed copy of Certification of Receipt of *Minimum Standards and Administrative Requirements*. Attached.
- ☒ 24. Copy of Group Schedule offered at agency.
- ☒ 25. Provide evidence of additional funding sources to support Question 12 of the Application.
- ☒ 26. Copy of sliding fee schedule if applicable.
- ☒ 27. Copy of telehealth policies.
- ☒ 28. Disclosure of Lobbying Activities. Attached.
- ☒ 29. Completed Application Checklist.

**City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division**

City of Albuquerque Substitute W-9

City of Albuquerque Substitute W-9 and instructions are online at:

<https://www.cabq.gov/dfa/online services/modified-w9-supplier-form>

Please be sure to include an email address to receive invoicing communications such purchase orders.

**City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division**

DRUG FREE WORKPLACE REQUIREMENT CERTIFICATION FORM

The agency certifies that it will provide a drug-free workplace by:

1. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the agency's workplace, and specifying the actions that will be taken against employees for violation of such prohibition;
2. Establishing a drug-free awareness program to inform employees of:
 - a. The dangers of drug abuse in the workplace;
 - b. The agency's policy of maintaining a drug-free workplace;
 - c. Any available drug counseling, rehabilitation, and employee assistance programs; and
 - d. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace.
3. Making it a requirement that each employee to be engaged in the performance of an agreement with the City be given a copy of the agency's drug-free workplace statement.
4. Notifying each employer that as a condition of employment under the City's agreement, that employee will:
 - a. Abide by the terms of the agency's drug-free workplace statement, and
 - b. Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace, no later than five (5) days after such conviction.
5. Notifying the City of Albuquerque, Department of Family and Community Services within ten (10) days after receiving an employee notice or otherwise receiving actual notice of an employee drug statute conviction for a violation occurring in the workplace.
6. Taking one of the following actions within thirty (30) days of receiving notice of an employee's drug statute conviction for a violation occurring in the workplace:
 - a. Taking appropriate personnel action against such an employee, up to and including termination;
 - b. or requiring such employee to participate satisfactorily at a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State or local health, law enforcement, or other appropriate agency; and
7. Making a good faith effort to continue to maintain a drug-free workplace through the implementation of the above requirements.

City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division

8. The agency also certifies that the agency's drug-free workplace requirements will apply to all locations where services are offered under the agreement with the City of Albuquerque. Such locations are identified as follows:

Street Address: 8200 Mountain Rd NE City: Albuquerque

State: NM Zip: 87110 E-mail: bobbiea@abqbh.com

Typed Name of Authorized Board Official: Bobbie Anderson

Title: Owner/Executive Director

Signature of Authorized Board Official: *Bobbie Anderson*

Date: 4/18/22

City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division

ACORD CERTIFICATE OF LIABILITY INSURANCE		Cert. ID: 10000 DATE (MM/DD/YYYY) 1/1/2009											
PRODUCER Madison & Sonnet, Inc. 4600 Coolidge Highway Royal Oak MI 48072 (248) 549-3319	THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.												
INSURED Sample Film Producer 1111 Thomas Ave Berkeley CA 94999	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: left;">INSURERS AFFORDING COVERAGE</th> <th style="text-align: left;">NAIC #</th> </tr> <tr> <td>INSURER A Sample Insurance Company</td> <td></td> </tr> <tr> <td>INSURER B Sample Insurance Company</td> <td></td> </tr> <tr> <td>INSURER C</td> <td></td> </tr> <tr> <td>INSURER D</td> <td></td> </tr> <tr> <td>INSURER E</td> <td></td> </tr> </table>	INSURERS AFFORDING COVERAGE	NAIC #	INSURER A Sample Insurance Company		INSURER B Sample Insurance Company		INSURER C		INSURER D		INSURER E	
INSURERS AFFORDING COVERAGE	NAIC #												
INSURER A Sample Insurance Company													
INSURER B Sample Insurance Company													
INSURER C													
INSURER D													
INSURER E													

COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

NAME	TYPE OF COVERAGE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YYYY)	POLICY EXPIRATION DATE (MM/DD/YYYY)	LIMITS
B	GENERAL LIABILITY	121456789	1/01/2009	1/01/2010	EACH OCCURRENCE \$ 1,000,000
	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY				AGGREGATE LIMIT \$ 50,000
	<input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> COMB				VEHICLE (ANY ONE PERSON) \$ 5,000
					PERSONAL & ADJUTORY \$ 1,000,000
					GENERAL AGGREGATE \$ 2,000,000
					PRODUCTS - COMPLETED \$ 1,000,000
A	AUTOMOBILE LIABILITY	33456789	1/01/2009	1/01/2010	COMBINED SINGLE LIMIT (Per accident) \$ 1,000,000
	<input checked="" type="checkbox"/> ANY AUTO				BODILY INJURY (Per person) \$
	<input type="checkbox"/> ALL COVERED AUTOS				BODILY INJURY (Per accident) \$
	<input type="checkbox"/> NON COVERED AUTOS				PROPERTY DAMAGE (Per person) \$
	<input checked="" type="checkbox"/> Hired Autos				PROPERTY DAMAGE (Per accident) \$
	<input checked="" type="checkbox"/> Non Covered Autos				
	Garage Liability				AUTOMOBILE - EA ACCIDENT \$
	<input type="checkbox"/> ANY AUTO				OTHER THAN EA ACCIDENT \$
					AUTOMOBILE - AGGREGATE \$
					AGGREGATE \$
					\$
					\$
	EXCESS/UMBRELLA LIABILITY				EACH OCCURRENCE \$
	<input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE				AGGREGATE \$
					\$
					\$
					\$
					\$
A	WORKERS COMPENSATION AND EMPLOYERS LIABILITY	34567891	1/01/2009	1/01/2010	<input checked="" type="checkbox"/> ALL STATE <input type="checkbox"/> OTHER \$
	ANY PROFESSIONAL LIABILITY (EXCEPT FOR PROFESSIONAL LIABILITY)				E.L. EACH ACCIDENT \$ 500,000
	Any One Person \$500,000				E.L. DISEASE - EA EMPLOYEE \$ 500,000
	Any One Person \$500,000				E.L. DISEASE - POLICY LIMIT \$ 500,000
B	OTHER PROPERTY	456789123	1/01/2009	1/01/2010	(see DESCRIPTION if coverage applies to this certificate.)

DESCRIPTION OF COVERAGE ADDITIONS (VEHICLES, EXCLUSIONS, ADDED BY ENDORSEMENT, SPECIAL PROVISIONS)

Sample Certificate Holder is named as Additional Insured and Loss Payee as their interests may appear.

CERTIFICATE HOLDER Sample Certificate Holder 1234 Main Street Royal Oak MI 48072	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 20 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT. BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES. AUTHORIZED REPRESENTATIVE
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ACORD 25 (2001/08)

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City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division

INSURANCE COVERAGE INSTRUCTIONS

The Contractor shall procure and maintain at its expense until final payment by the City for Services covered by the Agreement insurance in the kinds and amounts hereinafter provided with insurance companies authorized to do business in the State of New Mexico, covering all operations under this Agreement, whether performed by it or its agents. Before commencing the Services, the Contractor shall furnish to the City a certificate or certificates in form satisfactory to the city showing that it has complied with this Section. All certificates of insurance shall provide that thirty (30) days written notice be given to Director, Risk Management Department, City of Albuquerque, PO Box 1293, Albuquerque, New Mexico 87103, before a policy is canceled, materially changed, or not renewed. Various types of required insurance may be written in one or more policies. **The City shall be named as an additional insured under the Commercial General Liability (CGL) policy.**

In order for any of these coverages to be waived, Contractor will need to sign and return the Insurance Waiver Request form enclosed in this packet. Your Program Specialist will consult with the City Risk Management Department regarding approving the waiver.

If you have any questions, please contact your assigned Program Specialist.

BASIC INSURANCE REQUIREMENTS

For all City contracts for goods and/or services, it is required that all vendors/contractors maintain the following basic insurance coverages (and limits):

A. Commercial General Liability Insurance ("CGL"): A CGL insurance policy with combined limits of liability for bodily injury or property damage as follows:

\$ 2,000,000	Per Occurrence
\$ 2,000,000	Policy Aggregate
\$ 1,000,000	Products Liability/Completed Operations
\$ 1,000,000	Personal and Advertising Injury
\$ 5,000	Medical Payments

The CGL insurance policy must include coverage for all operations performed for the City by the Contractor, and the contractual liability coverage shall specifically insure the hold harmless provisions of the City's contract with the Contractor. The City shall also be listed as an "additional insured" by endorsement onto the CGL policy. Proof of this additional insured relationship shall be evidenced on the Certificate of Insurance (COI) and on the insurance endorsement.

B. Commercial Automobile Liability Insurance ("CAL"): A CAL policy with not less than a \$1,000,000 combined single limit of liability for bodily injury, including death, and property damage in any one occurrence. The CAL policy must include coverage for the use of all owned, non-owned, and hired automobiles, vehicles and other

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equipment both on and off work. This CAL policy cannot be a personal automobile liability insurance policy as most personal automobile liability policies exclude coverage for work related losses.

C. Workers' Compensation Insurance: Workers' Compensation Insurance for the Contractor's employees when required by, and in accordance with, the provisions of the Workers' Compensation Act of the State of New Mexico ("Act"). The Contractor must have three (3) or more employees to trigger the Act's workers' compensation insurance requirement. Per the Act, this number includes the owner of the business. If the

Contractor is not required to carry Workers' Compensation coverage, the Contractor will need to sign and return the Worker's Comp Statement enclosed in this packet.

ADDITIONAL INSURANCE COVERAGES

The following coverages should be considered based on the course and scope of the individual contract:

D. Professional Liability (Errors and Omissions) Insurance: Professional liability (errors and omissions) insurance in an amount not less than \$1,000,000 combined single limit of liability per occurrence with a general aggregate of \$1,000,000.

Professional liability insurance cannot be waived for medical directors, psychologists, psychiatrists, mental health counselors, laboratories.

E. Sexual Abuse Molestation Coverage: Sexual abuse molestation insurance in an amount not less than \$1,000,000 combined single limit of liability per occurrence with a general aggregate of \$1,000,000. This coverage should be required, unless specific circumstances that eliminate potential risks indicate otherwise, if the vendor/contractor will be working with, or in physical or virtual contact with, children under the age of 18 or a compromised client base (deaf and hard of hearing, blind, senior and older adults, persons with mental disabilities, intellectual disabilities and/or have a developmental disability).

F. Cyber Liability Coverage: Cyber liability insurance in an amount not less than \$2,000,000 combined single limit of liability per occurrence with a general aggregate of \$2,000,000. This coverage should be required, unless specific circumstances that eliminate potential risks indicate otherwise, if the vendor/contractor may have cybernetic access to the City's confidential information, taxpayer data, information technology, personnel, healthcare, accounting, or finance systems.

**City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division**

INSURANCE WAIVER REQUEST

Agency/Organization: Albuquerque Health Services LLC dba/Albuquerque Behavioral Health

Typed Name of Authorized Official of the Agency: Bobbie Anderson

Title: Owner/Executive Director

Signature: Bobbie Anderson Date: 4/18/22

Contractor requests the following insurance be waived. Please check **all** that apply and sign associated certifications.

☐ A. Commercial General Liability Insurance ("CGL")

Please provide an explanation for why you believe this insurance should be waived for your agency:

Signature: _____ Date: _____

☒ X-B. Commercial Automobile Liability Insurance ("CAL")

I hereby certify that neither I, nor employees or contractors employed by this agency, use vehicles in other than a commuting capacity. I further certify that should I, or any employees or contractors employed by this agency, use vehicles in any manner other than a commuting capacity, the agency will comply with the City of Albuquerque's Automobile Insurance requirements.

Signature: Bobbie Anderson Date: 4/18/22

☐ C. Workers' Compensation Insurance

I hereby certify that I employ fewer than three employees and am, therefore, not subject to the provisions of the Workers' Compensation Act of the State of New Mexico. I further certify that should I employ three or more persons during the term of my contract with the City, I will comply with the provisions of the New Mexico Workers' Compensation Act and provide proof of such compliance to the City of Albuquerque.

Signature: _____ Date: _____

**City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division**

☐ **D. Professional Liability (Errors and Omissions) Insurance**

Please provide an explanation for why you believe this insurance should be waived for your agency:

☐ **X-E. Sexual Abuse Molestation Coverage:**

I hereby certify that neither I, nor employees or contractors employed by this agency, will have unsupervised or one-on-one contact with children or compromised adults. I further certify that should I, or any employees or contractors employed by this agency, have unsupervised or one-on-one contact with children or compromised adults, the agency will comply with the City of Albuquerque's Sexual Abuse Molestation Coverage Insurance requirements.

Signature: *Bobbie Anderson* Date: 4/18/22

☐ **X-F. Cyber Liability Coverage**

I hereby certify that neither I, nor employees or contractors employed by this agency, will have cybernetic access to the City's confidential information, taxpayer data, information technology, personnel, healthcare, accounting, or finance systems. I further certify that should I, or any employees or contractors employed by this agency, have cybernetic access to the City's confidential information, taxpayer data, information technology, personnel, healthcare, accounting, or finance systems, the agency will comply with the City of Albuquerque's Cyber Liability Coverage Insurance requirements.

Signature: *Bobbie Anderson* Date: 4/18/22

For City of Albuquerque Use Only:

Insurance Waiver Approved:

By: _____

Title: _____

Date: _____

**City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division**

REPRESENTATIONS AND CERTIFICATIONS

The undersigned HEREBY GIVE ASSURANCE THAT:

The applicant agency named below will comply and act in accordance with all Federal laws and Executive Orders relating to the enforcement of civil rights, including but not limited to, Federal Code, Title 5, USCA 7142, Sub-Chapter 11, Anti-discrimination in Employment, and Executive Order number 11246, Equal Opportunity in Employment; and

That the applicant agency named below will comply with all New Mexico State Statutes and City Ordinances regarding enforcement of civil rights; and

That no funds awarded as a result of this request will be used for sectarian religious purposes, specifically that (a) there shall be no religious test for admission for services; (b) there shall be no requirement for attendance of religious services; (c) there shall be no inquiry as to a client's religious preference or affiliations; (d) there shall be no proselytizing; and (e) services provided shall be essentially secular, however, eligible activities, as determined by the fund source, and inherently religious activities may occur in the same structure so long as the religious activity is voluntarily and separated in time and/or location.

Agency Name Albuquerque Health Services LLC dba/Albuquerque Behavioral Health

Typed Name of Authorized Board Official: Bobbie Anderson

Title: Owner/Executive Director

Signature of Authorized Board Official: *Bobbie Anderson*

Date: 4/18/22

**City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division**

DEBARMENT, SUSPENSION, INELIGIBILITY AND EXCLUSION CERTIFICATION

I certify that the agency has not been debarred, suspended or otherwise found ineligible to receive funds by any agency of the executive branch of the federal government.

I further certify that should any notice of debarment, suspension, ineligibility or exclusion be received by the agency, the City of Albuquerque, Department of Family and Community Services will be notified immediately.

Agency: Albuquerque Health Services LLC dba/Albuquerque Behavioral Health

Typed Name of Authorized Board Official: Bobbie Anderson

Title: Owner/Executive Director

Signature of Authorized Board Official: *Bobbie Anderson*

Date: 4/18/22

**City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division**

**CERTIFICATION OF RECEIPT OF
MINIMUM STANDARDS AND ADMINISTRATIVE REQUIREMENTS**

The undersigned HEREBY CERTIFY THAT:

1. The agency/organization has been made aware that the ***Albuquerque Minimum Standards for Substance Abuse Treatment and Prevention Services***, Department of Family and Community Services, Division of Health & Human Services, revised January 2009, can be viewed at:
<https://www.cabq.gov/family/documents/minimumstandardsfy09final.pdf/view>.
2. The agency named below will adhere to the *Minimum Standards* in its operation of City-funded programs.
3. The agency/organization has been made aware that the ***Administrative Requirements for Contracts Awarded Under the City of Albuquerque***, Department of Family and Community Services, issued July 2019, can be viewed and downloaded at:
<https://www.cabq.gov/family/documents/administrative-requirements-coa-family-and-community-services-july-2019-nosp.pdf>.
4. The agency/organization named below will adhere to the *Administrative Requirements* in its operation of City-funded programs.

Name of Agency: Albuquerque Health Services LLC dba/Albuquerque Behavioral Health

Typed Name of Authorized Board Official: Bobbie Anderson

Title: Owner/Executive Director

Signature of Authorized Board Official: *Bobbie Anderson*

Date: 4/18/22

**City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division**

Disclosure of Lobbying Activities

Disclosure of Lobbying Activities form and instructions are online at:

Form: <https://www.gsa.gov/Forms/TrackForm/33144>

Instructions: https://apply07.grants.gov/apply/forms/instructions/SFLLL_1_2-V1.2-Instructions.pdf

**City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division**

Albuquerque Pay Equity Initiative Instructions

Information about the Albuquerque Pay Equity Initiative

All businesses submitting bids or proposals (to the City, County, or Water Authority) must include a valid Pay Equity Reporting Form or Certificate with their bid or proposal. The required form and additional details about the initiative can be found at the following link:

<https://www.cabq.gov/gender-pay-equity-initiative>

City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division

APPLICATION SUMMARY AND CERTIFICATION FORM

1. Agency Name: Albuquerque Health Services LLC dba/Albuquerque Behavioral Health		
2. Mailing Address (Include City, State, & Zip Code) 8200 Mountain Rd. NE Suite 106 Albuquerque, NM 87110	3. Agency Contact & Telephone Number Bobbie Anderson 505-830-6500 office 505-304-2473 cell	
4. City Program Name: P.A.T.H Substance Use Treatment Provider Network		
5. Due Date: 4/18/22 before 4pm (earlier submissions are highly recommended)	6. Date Submitted: 4/18/22	
7. Title of Applicant's Project and Brief Description: Application submission for continued acceptance in the City of Albuquerque's Substance Use Treatment Provider Network Program (THE PATH). The application describes Albuquerque Health Services LLC dba/ Albuquerque Behavioral Health's ability to provide high quality, ethical, comprehensive, and evidenced-based substance abuse treatment. We wish to continue to provide treatment services while being clinically appropriate and culturally relevant to meet all those in treatment. Our agencies' philosophy is to be able to provide significant positive change within the substance use/abuse population and assist in stabilizing individuals with co-occurring disorders within the community.		
8. Certification: It is understood and agreed by the undersigned that: 1) Any funds awarded as a result of this request are to be expended for the purposes set forth herein and in accordance with all applicable Federal, State, and City regulations and restrictions; and 2) the undersigned hereby gives assurances that this proposal has been prepared according to the policies and procedures of the above named Agency, obtained all necessary approvals by its governing body prior to submission, the material presented is factual and accurate to the best of her/his knowledge, and that s/he has been duly authorized by action of the governing body to bind the organization. The undersigned also hereby gives assurances that the agency will adhere to the Minimum Standards and the Administrative Requirements in its operation of City funded programs.		
a. Typed Name of Authorized Official of the Agency: Bobbie Anderson	b. Title Owner & Executive Director	c. Telephone Number 505-304-2473 (cell) 505-830-6500 (office)

City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division

d. Signature of Authorized Official of the Agency: <i>Bobbie Anderson</i>	e. Date Signed: 4/18/22
--	--------------------------------

NOTE: INCLUDE THIS COMPLETED FORM AS PAGE 1 OF THE APPLICATION.
FY-2023 PATH PROVIDER APPLICATION

Complete the Application below, providing concise and complete responses. Questions should be directed to Jeanné Padilla, Program Specialist, Behavioral Health and Wellness Division at jcpadilla@cabq.gov.

Type of Application: ☒ Adult
☐ Adolescent

Levels of Care: ☐ Level .5
☒ Level I
☐ Level II

1. Agency Information

Agency Name: Albuquerque Health Services LLC dba/Albuquerque Behavioral Health

Number of Years Established as an Agency: Thirteen (17) yrs. (began March 31, 2006) New Owner
April 16th 2018

Administrator: Bobbie Anderson

Address: 8200 Mountain Rd. NE, Suite 106 Albuquerque, NM 87110

Telephone #: 505-830-6500 office or 505-304-2473 cell Fax #: 505-830-6527

E-Mail Address: bobbiea@abqbh.com

Website Address: www.abqbh.com

Contact for Billing: Bobbie Anderson Telephone #: 505-830-6500 (office) 505-304-2473 (cell)

2. Languages in which therapeutic services can be provided: (Check all that apply.)

☒ English ☒ Spanish ☐ ASL ☐ Other languages (Specify): _____

3. Is your agency authorized to accept Medicaid? Yes

City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division

4. Describe your processes to ensure eligible clients are enrolled in Medicaid in order to maximize access to services.

Albuquerque Behavioral Health (ABH) works hard to ensure that each client receives treatment and funding for that treatment, is vital. We help clients when they first come to ABH to help apply for Medicaid coverage. The Medicaid coverage is a great benefit for the client. It not only covers substance abuse treatment it will allow the client to receive medical, vision, and dental coverage that is also, a need the client will have. The clients can receive Medicaid coverage also for their family. This is often important to help the client feel they are still providing something for their family, even though they might not have a job or be completely stable in their sobriety. Some Medicaid approval is for only family planning and would not cover substance abuse treatment. ABH is credentialed with most HMO's and all Medicaid insurers. The voucher program will only be utilized for those individuals who have a gap in funding.

Keeping clients engaged in treatment can be difficult especially if their funding is cut short or eliminated completely. We ensure that every client that is in treatment that wants to continue treatment that may experience their funding of the voucher being exhausted or losing a different funding source, we will allow the client to continue no matter what. If the client is engaged and doing well in their program we will work with them to help them continue in their recovery process. We will either give pro-bono services to the client, and then becomes free of charge to them, or we can work with them on a sliding fee scale or take small payments. We believe that a client feels better about earning their recovery when they participate in the process including the funding of their treatment.

Aftercare treatment and services will also be provided when funding is limited or exhausted. We certainly want to allow the client to continue until new funds can be arranged. We also work hard to secure other funding that would allow clients to have funding such as grant money or specialty programs and contracts with the state and city governments. We also have outside sponsors that donate money to help clients finish their treatment. We are very frugal minded when it comes to funding but very client focused when it comes to treatment. Our mission is not about the funding but about saving lives. Funding is a big resource to do that, but not always required.

5. Please indicate the days of the week and the hours that you provide services:

Hours of Operation	Hours You Admit Clients
Monday __ 9 a.m. 6 p.m.	Monday ____ 9a.m. ____ 6p.m.
Tuesday __ 9 a.m. 6 p.m.	Tuesday ____ 9a.m. ____ 6p.m.
Wednesday _ 9 a.m. 6 p.m.	Wednesday ____ 9a.m. ____ 6p.m.
Thursday _ 9 a.m. 6 p.m.	Thursday ____ 9a.m. ____ 6p.m.
Friday _ 9 a.m. 6 p.m.	Friday ____ 9a.m. ____ 6p.m.
Saturday upon Request & Availability	Saturday upon need-9-2pm
Sunday upon Request & Availability	Sunday upon need-9-2pm

Please Note: Any later hours needed for individualized care can be arranged per therapist's availability outside regular business hours specifically for crisis situations and follow-up sessions.

City of Albuquerque
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Behavioral Health & Wellness Division

6. Substance Use Treatment Program

- a. Describe your Substance Use Treatment program as you would describe it to a new client, including the agency's philosophy toward substance use treatment.

One of the biggest things that still impacts' the agency and client care was the implementation to treatment care through the Telehealth process due to the global pandemic. Our agency did suffer a tremendous loss of client engagement and administrative functioning for many months during the periods of time for the lockdowns and quarantine of the city. We are proud to announce that we did not stop any treatment sessions or close the agency due to the pandemic and have been able to provide a strong level of treatment and care for all clients regardless of funding. We implemented the strong need for additional training around Telehealth for the clinical staff as well as the education and practice with client navigation and Technology use for the Telehealth services. The agency found that many of our clients were not equipped with proper technology. We were able to purchase many phones and Wi-Fi connections to help clients maintain their treatment sessions. Maintaining treatment sessions was vital for each client that was still under legal supervision such as probation and parole or any specialty court as any interruption in their Treatment Services could cause them to return back to incarceration and also stop their earning requirements for moving forward within their programming. Those two events would have been devastating for each client as some were working very hard staying sober. The agency also implemented several additional levels of service such as food pantry, utility payment, and rent assistance, although the agency wasn't financially able to help every client but if the need arose the agency stepped in and did assist. Many of the clients also needed assistance gaining unemployment benefits which we navigated all meetings and helped complete all applications for assistance in all areas of functioning such as welfare, housing, transportation, and unemployment compensation.

During the holiday season we found that many clients were in need of more support with food, Utility payments, transportation, Christmas presents and family gift-giving and medical assistance for medical bills and or funeral expenses. The agency was able to contribute to their client base and successfully donate many charitable contributions. The agency was able to deliver groceries do more than 100 needy families and provided weekly and or monthly food boxes and specific holiday meals for both Thanksgiving and Christmas. The agency donated more than \$50,000 in toys to the Toys-for-Tots foundation and was supported with veterans and Marines for an agency event and client outreach. The agency also was able to provide two automobiles to families without transportation. The clients had received those automobiles free and clear with 1 year of insurance and complete registration provided. The agency also helped with burial expenses for two clients that had died due to drug overdoses. The agency also financially assisted on two clients, whom had deaths of close family members that were due to covid. The agency was able to provide Monies to help with the funeral arrangements and expenses to the family. The agency felt that covid did impact many of the clients and their families where many significant family members were lost due to the virus. The agency was praised by the New Mexico Department of Corrections and was publically acknowledged that

City of Albuquerque
Department of Family & Community Services
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the generosity of the agency and its staff exceeded praiseworthy and perhaps showed the best demonstration that the world is abundant when people commit themselves to improving the lives of fellow human beings. The effort of the agency and the staff during these exceptional community outreach efforts was truly an opportunity for clients to grow and change with both Grace and Dignity.

- b. Are there any substances for which your agency DOES NOT provide treatment? NO
- c. Describe Recovery Support Services either provided at or through an MOU with your agency.
- ABH reinforces gains made in the client treatment by offering recovery support services. ABH understands that having continuous recovery support after out-patient treatment helps to improve the quality of life of clients extending into long-term recovery model. ABH recovery support services include a continuum of care, mutual help groups (such as 12-step programs), and peer support and collaboration. ABH offers an extended maintenance recovery group called aftercare. Aftercare is a step-down level of treatment where the client only needs to attend one group weekly. This group is conducted virtual through the pandemic where the client has been familiarized. The aftercare group consists of fellow recovery clients that have finished their programming or reached their treatment goals and now have moved into the aftercare phase. Clients may attend the aftercare group for up to a year or longer. ABH encourages each client that completes our recovery program and maintains one year of sobriety, are able to become a recovery mentor to others in higher levels of care.
- ABH recovery support programs are also provided in a community setting where fellow recovering individuals can share their experiences, provide mutual support to each other's struggles with drug and alcohol problems, and in other ways support a substance-free lifestyle. ABH emphasizes to each client that recovery support services are not a substitute for clinical treatment. Recovery research shows evidence that supports the effectiveness of peer recovery support services and long-term sobriety.

7. Clinical Staffing

- a. Identify Clinical Supervisors in your organization. Complete table below.

Name	Licensure Level	Years of Experience at this Level
Bobbie Anderson	LPCC	6
Margaret Garberina	LADAC, LPCC, Ph.D.	33

- b. Explain the process you use to adhere to the *Minimum Standards* regarding clinical supervision activities. Include a copy of your clinical supervision workshops and a copy of the agency's clinical supervision policy if applicable.

Additional updates to our clinical supervision process have been where we currently include the Staffing around the Telehealth process. Some of the clinical staff still feels due to the pandemic they are extremely high-risk and are working through their concerns about

City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division

returning back to face-to-face contact with clients. Additional coverage of Telehealth ethical guidelines and communication along with proper documentation is consistently reviewed.

- c. List all staff that provide services including substance use treatment, case manager, and mental health, in the table below. Add additional lines in the table as necessary.

Staff	Title	Licensure	Years At This Licensure Level	Substance Use Training	Other Certifications
Bobbie Anderson	Owner & Executive Director	LPCC	6	Matrix Model, 11 yrs. in field of addiction & mental health	NM Continuing Education Provider, Matrix, NCC, NGCC, ACA, Seeking Safety, Addictions, Trauma, Crisis Intervention (to many to list)
Margaret Garberina Ph.D.	Clinical Supervisor	LADAC, LPCC, Ph.D.	33	43 yrs. in the field of addiction & Mental Health	NM Continuing Education Provider, Matrix, Anger Management (to many to list)
Elesha Fetrow	Therapist	LPCC	2	7 yrs. working with children & families, & mental health, & addiction	Nurturing Heart Parenting Facilitator
John Krone	Therapist	LMHC	9	10 yrs. in the field of addiction & mental health	MRT
Samara Konan	Therapist	LMSW	5	6 yrs. in the addiction & mental health	

City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division

Ruben Porter	Therapist	LADAC	14	17 yrs. in the field of addiction & 10 yrs. in Mental Health	MRT
David Maestas	Therapist	LADAC	22	27yrs. in the field of addiction & 15 yrs. in mental health	MRT. Matrix
Don Smith	Therapist	LADAC	26	31yrs. in the field of addiction & 20 yrs. in mental health	MRT, DV, Matrix
Rhonda Hudson	Therapist	LMHC	6	9 years working with children and addiction	

- d. List all interns that provide services including substance use treatment, case manager, and mental health, in the table below. Add additional lines in the table as necessary.

Staff	Title	Licensure	Years At This Licensure Level	Substance Use Training	Other Certifications

8. Populations Served

- Specify any population your agency prefers to work with and is staffed and specifically trained to treat. No Changes
- Specify any populations that your agency prefers not to work with or is not staffed/trained to treat. No Changes
- Describe how your agency provides specific treatment for any special populations and describe what training your staff has received to work with this specific population.

Although it is not new for the agency to encompass all needs of the client when coming in for treatment services we are Vigilant currently around the pandemic issues of additional anxiety and fear, health concerns, and daily living needs.

City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division

- d. For Applications to serve an adolescent population only: What qualifies your agency to provide treatment to adolescents?

9. Case Management

- a. Describe how your agency determines a client is in need of Case Management Services.
 No changes-however we have seen a high level of increase for case management due to the pandemic.
- b. Describe the case management services that are provided on site. No changes
- c. Describe in detail how your case managers assist clients in accessing services.
 Although our agencies Case Management Services are very thorough we have had an increase to our financial obligation to the client in the sense of providing technology such as cell phones and Wi-Fi connection to help assist clients for their Telehealth services and internet needs. Daily navigation is provided too many clients struggling to navigate the technology. This is all new and due to the tele-health procedures caused by the pandemic.

10. Mental Health Services

- a. Does your agency provide mental health services with licensed and qualified mental health practitioners?
 Yes ☒ No ☐ If Yes, please complete 10b & 10c. If No, go to 11.
- b. Please check all mental health services that your agency provides to clients.
☒ Mental Health Assessment/Diagnosis ☒ Mental Health Therapy (Not substance use Tx.)
☐ Psychotropic Medication Evaluation ☐ Psychological Testing Services
- c. For each item checked above, please provide a description of how the services are provided.
 No changes

11. Children and Adolescent Safety (only applicable for Applications to serve an adolescent population)

- a. Please describe how your agency provides for adolescent safety if both adults and adolescents are treated at the same site. NA

12. Vouchered Services

- a. Since City voucher funds may not cover an entire course of treatment, the City is looking for evidence that agencies are able to leverage funds to sustain clients in treatment. Please list specifically what measures your agency takes to continue treatment for clients once the voucher funds have been expended. No Changes

**City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division**

13. Discharge Planning and Aftercare

- a. Describe your agency's discharge planning procedures to ensure successful discharge of clients. Include a copy of the agency's discharge planning policy. No Changes
- b. Does your agency provide aftercare services on site? If yes, describe how you ensure client is engaged in aftercare (groups, life skills, peer support etc.). If not, describe how you ensure client is engaged in aftercare at other entities. No Changes

14. Include the Proposal Summary and Certification Form (page 24 of this Application packet) as the first page to this Application with all appropriate signatures. Applications without this form will not be accepted.

**City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division**

APPENDIX A

ASAM CRITERIA AND REQUIRED SERVICE MIX

Provide a SEPARATE Appendix A for Type of Application and each Level of Treatment for which you are applying.

1. Type of Application

(check ONE only – use another Appendix A if applying for both):

- ☒ Adult
☐ Adolescent

2. Identify Level of Treatment

(check ONE only – use a separate Appendix A for each level applying for):

- ☐ Level .5
☒ Level I
☐ Level II.I

- 3. Please review pages 4-7 in this Application Packet. Based on the ASAM Criteria detailed on pages 4-7, and at www.ASAM.org; describe how your agency meets or exceeds that ASAM Criteria for the level of care marked above. No Changes**
- 4. Please review pages 7-9 in this Application Packet. Based on the required Service Mix detailed on pages 7-9, describe how your agency meets or exceeds the required Service Mix for the level of care marked above. No Changes**
- 5. FOR ADOLESCENT APPLICATIONS ONLY: How does your treatment methodology differ between your adolescent and adult substance use treatment programs, for the specific level of care addressed on this Appendix?**



CITY OF ALBUQUERQUE BUSINESS REGISTRATION

CITY OF ALBUQUERQUE
P.O. BOX 1293
ALBUQUERQUE, NM 87102

ALBUQUERQUE HEALTH SERVICES LLC
5413 RAYLITO DEL LUNA NE
ALBUQUERQUE NM 87111

CITY OF ALBUQUERQUE

ALBUQUERQUE HEALTH SERVICES LLC (ALBUQUERQUE BEHAVIORAL
HEALTH)
8200 MOUNTAIN ROAD PL NE
ALBUQUERQUE NM

PERMIT NO: COM-2018-349330

PROGRAM: BUSINESS REGISTRATION

EFFECTIVE FROM: 03/27/2022 THROUGH: 03/26/2023

HAVING COMPLIED WITH THE FEE REQUIREMENTS OF CHAPTER 13 ARTICLE 1 OF THE REVISED ORDINANCES,
REGISTRATION OR LICENSING WITH THE CITY OF ALBUQUERQUE AND PAYMENT OF FEES DOES NOT CONSTITUTE A
WAIVER OF ANY REQUIREMENTS OR PROVISIONS CONTAINED AT ANY LAW.
THE ACTIVITY/BUSINESS PROPOSED TO BE CONDUCTED AT ANY LOCATION WITHIN THE CITY SHALL BE APPROVED BY
THE CITY'S ZONING ENFORCEMENT OFFICER PRIOR TO COMMENCING THE ACTIVITY/BUSINESS.

PLANNING DEPARTMENT - CODE ENFORCEMENT DIVISION

WWW.BIZREG.CABQ.GOV

(505) 924-3890

POST IN A CONSPICUOUS PLACE



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

03/16/2022

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Alpha & Omega 2487 S Gilbert Road Ste 106-505 Gilbert, AZ 85295	CONTACT NAME: Shauna Murphy PHONE (A/C, No., Ext): 480 792 1000 E-MAIL ADDRESS: shauna@alphaomegafg.com FAX (A/C, No): 480-792-6797
INSURER(S) AFFORDING COVERAGE	
INSURER A: SENTINEL INS CO LTD	
NAIC #	
11000	
INSURED Albuquerque Health Services LLC dba Albuquerque Behavioral Health 8200 Mountain Rd NE Ste 100 Albuquerque, NM, 87110-7835	
INSURER B:	
INSURER C:	
INSURER D:	
INSURER E:	
INSURER F:	

COVERAGES**CERTIFICATE NUMBER:****REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER <input type="checkbox"/> POLICY <input type="checkbox"/> PRO. JECT <input type="checkbox"/> LOC <input type="checkbox"/> OTHER						EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COMP/OP AGG \$ \$
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input type="checkbox"/> RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$ \$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input type="checkbox"/> Y <input checked="" type="checkbox"/> N If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		59WFCAB4N3G	04/16/2022	04/16/2023	PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/> E L EACH ACCIDENT \$ 500,000 E L DISEASE - EA EMPLOYEE \$ 500,000 E L DISEASE - POLICY LIMIT \$ 500,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Out-patient Counseling Services

City of Albuquerque
 Risk Management
 PO BOX 1293
 Albuquerque, NM 87103
 Is listed as additional insured

CERTIFICATE HOLDER**CANCELLATION**

City of Albuquerque Risk Management PO BOX 1293 Albuquerque, NM 87103	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE Shauna Murphy
--	--



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

03/01/2022

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Hiscox Inc. 520 Madison Avenue 32nd Floor New York, New York 10022	CONTACT NAME: PHONE (A/C, No, Ext): (888) 202-3007 FAX (A/C, No): E-MAIL ADDRESS: contact@hiscox.com												
INSURER(S) AFFORDING COVERAGE													
INSURED ALBUQUERQUE HEALTH SERVICES, LLC DBA ABH DBA ABH 8200 MOUNTAIN RD NE SUITE 100 ALBUQUERQUE, NM 87110	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">INSURER A: Hiscox Insurance Company Inc</td> <td style="width: 20%;">NAIC #: 10200</td> </tr> <tr><td>INSURER B:</td><td></td></tr> <tr><td>INSURER C:</td><td></td></tr> <tr><td>INSURER D:</td><td></td></tr> <tr><td>INSURER E:</td><td></td></tr> <tr><td>INSURER F:</td><td></td></tr> </table>	INSURER A: Hiscox Insurance Company Inc	NAIC #: 10200	INSURER B:		INSURER C:		INSURER D:		INSURER E:		INSURER F:	
INSURER A: Hiscox Insurance Company Inc	NAIC #: 10200												
INSURER B:													
INSURER C:													
INSURER D:													
INSURER E:													
INSURER F:													

COVERAGES**CERTIFICATE NUMBER:****REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:	Y		P100.209.995.3	04/15/2022	04/15/2023	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000 MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input type="checkbox"/> RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below						PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/> E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
A	Professional Liability	Y		P100.209.163.3	04/15/2022	04/15/2023	Each Claim: \$ 1,000,000 Aggregate: \$ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Out-patient Counseling Services . City of Albuquerque / Risk Management. PO BOX 1293. Albuquerque NM 87103 / Listed as additional Insured

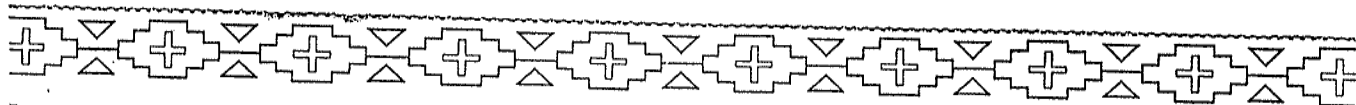
CERTIFICATE HOLDER

City of Albuquerque / Risk Management
 PO BOX 1293
 Albuquerque, NM 87103

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE



State of New Mexico
REGULATION & LICENSING DEPARTMENT
Counseling and Therapy Practice Board



THIS IS TO CERTIFY THAT

Bobbie J. Anderson

LICENSE NO. CCMH0176631

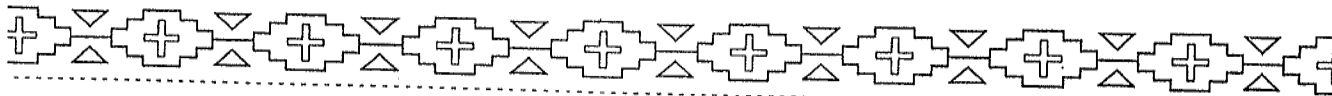
Having complied with the provisions of the Professional Counseling and Therapy Act is
hereby granted a license to practice as a

Clinical Mental Health Counselor (LPCC)

ISSUE DATE: 09/14/2015

DATE EXPIRES: 09/30/2022

THIS CERTIFICATE MUST BE CONSPICUOUSLY POSTED IN PLACE OF BUSINESS.



State of New Mexico

**Counseling and Therapy Practice
Board**



NMRLD
NEW MEXICO
REGULATION &
LICENSING DEPARTMENT



HEREBY CERTIFIES THAT

Bobbie Anderson

HAVING GIVEN SATISFACTORY EVIDENCE OF THE COMPLETION OF PROFESSIONAL
AND OTHER REQUIREMENTS PRESCRIBED BY LAW
IS GRANTED A LICENSE TO PRACTICE IN THE STATE OF NEW MEXICO AS A

Continuing Education Units Provider

License No. CCE0179321

Issued 01/26/2016

Expires 09/30/2022

THIS LICENSE SHOULD BE CONSPICUOUSLY POSTED IN PLACE OF BUSINESS OR AS REQUIRED BY LAW

Certificate of Completion

This Certificate is Awarded to
Bobbie Anderson

For Training on
Counselor Supervision
July 10th 2021
and is awarded 8 hours of Continuing Education Credits

Approved by New Mexico Counseling and Therapy Practice Board
Sponsored by: Listening Woman
Margaret Garberina PH.D, LPCC, LADAC CEU Provider # CCE 0077401
Expiration: 09/30/2022

Margaret A. Garberina

Margaret Garberina PH.D, LPCC, LADAC

7. 10. 21.
DATE: 07/10/21

THIS IS TO CERTIFY THAT

Margaret Ann Garberina
Counseling and Therapy Practice Board

Is licensed / registered by the New Mexico Regulation and Licensing Department
in accordance with provisions of laws in the State of New Mexico

License / Registration No. CCE0077401	License / Registration Type Continuing Education Units Provider
Issue Date 10/02/2002	Expiration Date 09/30/2022

The bearer is prohibited by law from using this identification card to give the impression that they are in any way connected with a governmental agency

Signature of holder:
Margaret Ann Garberina

THIS IS TO CERTIFY THAT

Margaret Ann Garberina
Counseling and Therapy Practice Board

Is licensed / registered by the New Mexico Regulation and Licensing Department
in accordance with provisions of laws in the State of New Mexico

License / Registration No. CAD3445	License / Registration Type Alcohol and Drug Abuse Counselor
Issue Date 04/29/1997	Expiration Date 09/30/2023

The bearer is prohibited by law from using this identification card to give the impression that they are in any way connected with a governmental agency

Signature of holder:
Margaret Ann Garberina

THIS IS TO CERTIFY THAT

Margaret Ann Garberina
Counseling and Therapy Practice Board

Is licensed / registered by the New Mexico Regulation and Licensing Department
in accordance with provisions of laws in the State of New Mexico

License / Registration No. CCMH0085811	License / Registration Type Clinical Mental Health Counselor (LMHC)
Issue Date 09/06/2005	Expiration Date 09/30/2022

The bearer is prohibited by law from using this identification card to give the impression that they are in any way connected with a governmental agency

Signature of holder:
Margaret Ann Garberina

CERTIFICATE OF COMPLETION

Is Presented to:

Margaret Garberina

Who has completed training for

Given on the July 30th 2021

And is awarded 8 hours Continuing Education Credits (CEU) For Clinical Supervision

Approved by New Mexico Counseling and Therapy Practice Board

Sponsored by: Albuquerque Behavioral Health

Provider # 0179321 Expiration: 09/30/2021

Provider Bobbie Anderson 

To all Participants:

If you were dissatisfied with the workshop, please contact the Counseling and Therapy Practice Board Immediately

This digital copy of your license is to be used for limited purposes only and does not replace the official license issued and mailed by the New Mexico Regulation and Licensing Department. This digital copy may be used for insurance credentialing or for other limited purposes when an official license is not available. This digital copy should not be used for public display, except for temporary purposes, if the license is required to be displayed at the licensee's primary place of business. Additional copies or replacements of an official license may be ordered for a fee online through the licensing portal.



State of New Mexico

Counseling and Therapy Practice Board

HEREBY CERTIFIES THAT

Elesha Fetrow

HAVING GIVEN SATISFACTORY EVIDENCE OF THE COMPLETION OF
PROFESSIONAL AND OTHER REQUIREMENTS PRESCRIBED BY LAW
IS GRANTED A LICENSE TO PRACTICE IN THE STATE OF NEW MEXICO AS A

Licensed Professional Clinical Counselor (LPCC)

License No. CCMH0210901

Issued 04/07/2020

Expires 09/30/2023

THIS LICENSE SHOULD BE CONSPICUOUSLY POSTED IN PLACE OF BUSINESS OR AS REQUIRED BY LAW

State of New Mexico
REGULATION & LICENSING DEPARTMENT
Counseling and Therapy Practice Board



THIS IS TO CERTIFY THAT

John D. Krone

LICENSE NO. CMH0155071

Having complied with the provisions of the Professional Counseling and Therapy Act is
hereby granted a license to practice as a

Licensed Mental Health Counselor

ISSUE DATE: 11/27/2012

DATE EXPIRES: 09/30/2022

THIS CERTIFICATE MUST BE CONSPICUOUSLY POSTED IN PLACE OF BUSINESS.

State of New Mexico
REGULATION & LICENSING DEPARTMENT
Board of Social Work Examiners



THIS IS TO CERTIFY THAT

Samara D Konan

LICENSE NO. M-10530

Having complied with the provisions of the Professional Social Work Act is
hereby granted a license to practice as a

Licensed Masters Social Worker

ISSUE DATE: 10/19/2018

DATE EXPIRES: 07/01/2022

THIS CERTIFICATE MUST BE CONSPICUOUSLY POSTED IN PLACE OF BUSINESS

This digital copy of your license is to be used for limited purposes only and does not replace the official license issued and mailed by the New Mexico Regulation and Licensing Department. This digital copy may be used for insurance credentialing or for other limited purposes when an official license is not available. This digital copy should not be used for public display, except for temporary purposes, if the license is required to be displayed at the licensee's primary place of business. Additional copies or replacements of an official license may be ordered for a fee online through the licensing portal.



State of New Mexico

Counseling and Therapy Practice Board

HEREBY CERTIFIES THAT

Ruben Porter

HAVING GIVEN SATISFACTORY EVIDENCE OF THE COMPLETION OF
PROFESSIONAL AND OTHER REQUIREMENTS PRESCRIBED BY LAW
IS GRANTED A LICENSE TO PRACTICE IN THE STATE OF NEW MEXICO AS A

Alcohol and Drug Abuse Counselor

License No. CAD0133751

Issued 07/25/2010

Expires 09/30/2023

THIS LICENSE SHOULD BE CONSPICUOUSLY POSTED IN PLACE OF BUSINESS OR AS REQUIRED BY LAW



NMRLD

NEW MEXICO
REGULATION &
LICENSING DEPARTMENT

State of New Mexico

**Counseling and Therapy Practice
Board**



HEREBY CERTIFIES THAT

David Maestas

HAVING GIVEN SATISFACTORY EVIDENCE OF THE COMPLETION OF PROFESSIONAL
AND OTHER REQUIREMENTS PRESCRIBED BY LAW
IS GRANTED A LICENSE TO PRACTICE IN THE STATE OF NEW MEXICO AS A

Alcohol and Drug Abuse Counselor

License No. CAD0128971

Issued 01/21/2010

Expires 09/30/2023

THIS LICENSE SHOULD BE CONSPICUOUSLY POSTED IN PLACE OF BUSINESS OR AS REQUIRED BY LAW

THIS IS TO CERTIFY THAT
Donald Smith

Counseling and Therapy Practice Board

is licensed / registered by the New Mexico Regulation and Licensing Department
in accordance with provisions of laws in the State of New Mexico

License / Registration No. CAD0102461	License / Registration Type Alcohol and Drug Counselor
---	--

Issue Date 04/03/2007	Expiration Date 09/30/2022
---------------------------------	--------------------------------------

The bearer is prohibited by law from using this identification card to give the
impression that they are in any way connected with a governmental agency

Signature of holder:

Donald Smith
13228 Panorama Loop NE
Albuquerque NM 87123

State of New Mexico
REGULATION & LICENSING DEPARTMENT
Counseling and Therapy Practice Board



THIS IS TO CERTIFY THAT

Donald Smith

LICENSE NO. CAD0102461

Having complied with the provisions of the Professional Counseling and Therapy Act is
hereby granted a license to practice as a

Alcohol and Drug Counselor

ISSUE DATE: 04/03/2007

DATE EXPIRES: 09/30/2022

THIS CERTIFICATE MUST BE CONSPICUOUSLY POSTED IN PLACE OF BUSINESS.

State of New Mexico

REGULATION & LICENSING DEPARTMENT
Counseling and Therapy Practice Board



THIS IS TO CERTIFY THAT

Rhonda L. Harper

LICENSE NO. 0151671

Having complied with the provisions of the Professional Counseling and Therapy Act is
hereby granted a license to practice as a

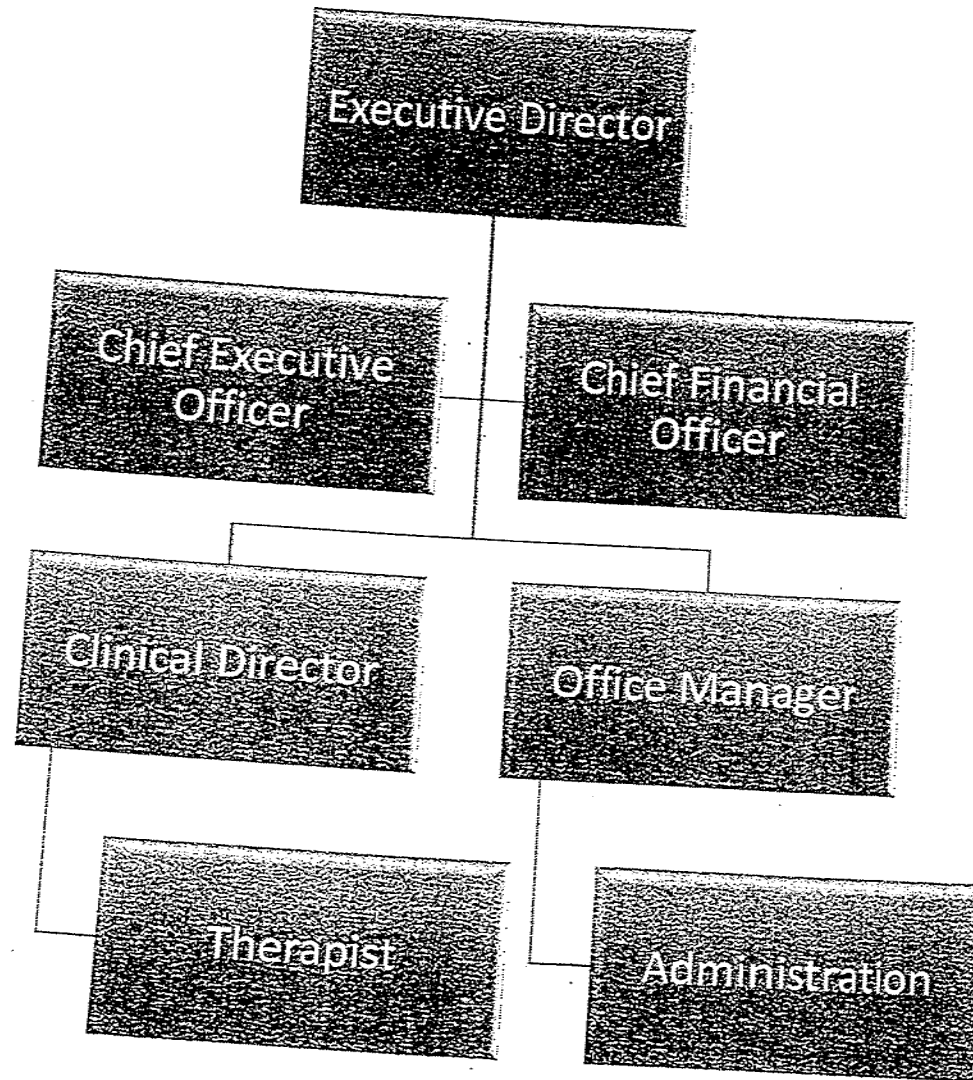
Licensed Mental Health Counselor

ISSUE DATE: 07/23/2012

DATE EXPIRES: 09/30/2022

THIS CERTIFICATE MUST BE CONSPICUOUSLY POSTED IN PLACE OF BUSINESS.

ABH Organizational Chart



OFFICE OF THE SECRETARY OF STATE

NEW MEXICO

Certificate of Good Standing and Compliance

IT IS HEREBY CERTIFIED THAT:

ALBUQUERQUE BEHAVIORAL HEALTH, LLC
2714228

the above named entity, a Company organized under the laws of New Mexico, is duly authorized to transact business in New Mexico as a Domestic Limited Liability Company, under the

Limited Liability Company Act

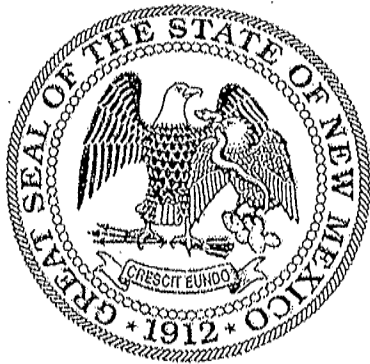
53-19-1 to 53-19-74 NMSA 1978

having filed its Articles of Organization on April 14, 2006, and Certificate of Organization Issued as of said date.

It is further certified that the fees due to the Office of the Secretary of State which have been assessed against the above named entity have been paid to date and the entity is in good standing and duly authorized to transact business as its existence has not been revoked in New Mexico. This certificate is not to be construed as an endorsement, recommendation, or notice of approval of the entity's financial condition or business activities and practices.

Certificate Issued: **September 22, 2017**

In testimony whereof, the Office of the Secretary of State has caused this certificate to be signed on this day in the City of Santa Fe, and the seal of said office to be affixed hereto.



Maggie Toulouse Oliver

Maggie Toulouse Oliver
Secretary of State

Certificate Validation #: 0014297

certificate issued electronically from the New Mexico Secretary of State's office is immediately valid and effective. The validity of a certificate may be established by viewing the Certificate Validation option on the Business Filing System at <https://portal.sos.state.nm.us/bfs/online> and following the instructions displayed under Certificate Validation.

ALBUQUERQUE BEHAVIORAL HEALTH HIPAA CONFIDENTIALITY AGREEMENT

I acknowledge that during the course of performing my assigned duties at Albuquerque Behavioral Health I may have access to, use, or disclose confidential health information. I hereby agree to handle such information in a confidential manner at all times during and after my employment and commit to the following obligations:

- I will use and disclose confidential health information only in connection with and for the purpose of performing my assigned duties.
- I will request, obtain, and communicate confidential health information only as necessary to perform my assigned duties and shall refrain from requesting, obtaining and communicating any confidential health information that is not necessary to accomplish my assigned duties.
- I will take reasonable care to properly secure confidential health information in my care and will take steps to ensure that others cannot view or access such information. When I am away from my workstation or when my tasks are completed, I will ensure that any such information is properly stored.
- I understand that medical records are protected under applicable state laws governing health care information that relates to mental health services and under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2), and cannot be released without written consent of the client or clients' parent or legal guardian.

I understand that as an employee and/ or independent contractor of Albuquerque Behavioral Health, I am a health care provider, the use and disclosure of patient information is governed by the rules and

regulations established under HIPAA, the Health Insurance Portability and Accountability Act of 1996, and related policies and procedures of Albuquerque Behavioral Health.

Therefore, with regard to patient information, I commit to the following additional obligations;

- I will use and disclose confidential health information solely in accordance with the federal and company policies set forth above or elsewhere. I also agree to familiarize myself with any periodic updates or changes to such policies in a timely manner.
- I will immediately report any unauthorized use or disclosure of confidential health information that I become aware of to the appropriate.

I also understand and agree that my failure to fulfill any of the obligations set forth in this Agreement and/or my violation of any terms of this Agreement shall result in my being subject to appropriate disciplinary action, up to and including, termination of employment.

Employee/Independent Contractor Signature: _____

Employee/Independent Contractor Printed Name: _____

Date: _____

Management Signature: _____

Date: _____

ALBUQUERQUE BEHAVIORAL HEALTH CLINICAL POLICIES AND PROCEDURES

Policy Number: 2106

Effective Date: 4-1-06

Revision Date: N/A

Subject: Confidentiality and Client Charts

POLICY:

All information pertaining to a client is confidential, including information concerning whether or not a client has actually utilized services of Albuquerque Behavioral Health, LLC.

Other Corresponding Policies:

- Charts
- Client Access to Information
- HIPAA-Consent for Use or Disclosure of Protected Health Information (HIPAA-2)
- HIPAA-Authorization for Use or Disclosure of Protected Health Information (HIPAA-3)
- HIPAA-Accounting for Disclosure of Protected Health Information (HIPAA-4)
- HIPAA-Confidentiality of Client/Membership Data (HIPAA-11)
- HIPAA-Confidentiality of Client Data for Staff Member/Executives/Celebrities (HIPAA-13)
- HIPAA-Fax Confidentiality and Security (HIPAA-14)
- HIPAA-Retention and Disposal of Data and Output (HIPAA-18)
- HIPAA-Policy on Confidentiality (HIPAA-19)
- Confidentiality
- Documentation Requirements

PROCEDURE**Client Charts**

Any information pertaining to the client is confidential. This provision covers information about a client's attendance, absences, physical whereabouts, or status as a client. The disclosure that a person is or is not attending a program, is prohibited except where a referring agency may be told if an individual has never made initial contact with Albuquerque Behavioral Health, LLC. This exception does not apply to family members of potential clients - only to known referral sources, such as Human Services, Departments of Probation, the Courts, Police, Sheriff's Office and other mental health or medical facilities). This exception allows Albuquerque Behavioral Health, LLC to maintain a good working relationship with other agencies and allows for necessary communications to effect smooth referrals. Individuals who have never contacted the agency do not have a professional relationship with the agency. Any improper requests for information must be refused. If in doubt about requested information, refer the question to the Clinical Director or Executive Director.

Any document or list indicating a client's name must be securely locked at night and kept out of sight at all times when other clients are present. Names of clients must not be mentioned in the presence of other clients. Discussion about clients should be in the course of clinical or administrative business and should be conducted behind closed doors.

Exception to Rules of Confidentiality

ALBUQUERQUE BEHAVIORAL HEALTH CLINICAL POLICIES AND PROCEDURES

Policy Number: 2106

Effective Date: 4-1-06

Revision Date: N/A

Subject: Confidentiality and Client Charts

- **Criminal Activity:** When a crime has been committed on the premises, the staff may report the crime to law enforcement personnel, but such reports shall not identify the suspect as a client.
- **Imminent Danger to Self:** Albuquerque Behavioral Health, LLC staff are required by law to notify such individuals as may be necessary to prevent a client from harming him or herself. If the danger is not imminent, then the dangerous situation should be discussed with the Clinical Director or Executive Director before further action is taken.
- **Danger to Others:** Albuquerque Behavioral Health, LLC staff are required by law to notify such individuals as may be necessary to prevent a client from harming others. If the intended victim is known, that person should be notified; but only after consultation with the Clinical Director or Executive Director, unless the threat is imminent.
- **Child Abuse, Child Neglect or Child Assault:** All personnel of Albuquerque Behavioral Health, LLC are required by law to report any knowledge of child abuse, child neglect, or child sexual assault. Even instances of sexual abuse which occurred several years ago should be reported if the perpetrator can be identified. If in doubt about reporting requirements, ask the Clinical Director or Executive Director.
- **Insurance Reimbursement or Collection for Outstanding Debts:** Albuquerque Behavioral Health, LLC staff may release such minimal information as may be necessary to collect outstanding debts or collect from insurance companies. The Clinical Director or Executive Director must approve disclosure of information under these circumstances.
- **Medical Emergencies and Continuity of Care:** In the case of bona fide medical emergencies, information that may be necessary to meet the demands of the emergency situation may be released to personnel responding to the emergency. The client's family may also be notified if such disclosure is necessary to assist in treatment and is in the best interest of the client.

If a client is taking medication, such information may be disclosed to medical personnel who are treating the client, with or without the client's permission.
- **Incapacitation:** If the client is incapacitated for any reason, information may be released if it is necessary to make a sound determination about appropriate emergency treatment.
- **Record of Disclosure:** Any staff member making an oral disclosure in an emergency situation must make a written note showing the client's name, date of the emergency, nature of the emergency, the nature of the information released, and the name(s) of individual(s) who received the information.

ALBUQUERQUE BEHAVIORAL HEALTH CLINICAL POLICIES AND PROCEDURES

Policy Number: 2106

Effective Date: 4-1-06

Revision Date: N/A

Subject: Confidentiality and Client Charts

- **Research, Audit, and Program Evaluations:** The contents of a client chart may be disclosed (with or without written client authorization) to qualified personnel for the purposes of conducting scientific research, management audits, financial audits, or program evaluations. However, the personnel to whom disclosure is made are prohibited from identifying individual clients in any report, evaluation, or any other manner.
- **Financial/Administrative Reviews:** When personnel who lack the training to conduct scientific research review program records, such reviews will be confined to administrative and financial records. Under no circumstances will non-clinical personnel be shown therapist case notes or similar clinical charts. Program records should be organized so that financial and administrative records are separate from clinical records.
- **Release to Qualified Personnel:** The Executive Director and all Albuquerque Behavioral Health, LLC staff members must use extreme caution in determining whether or not a person from another agency is qualified to receive the information being disclosed. No staff member should release any charts, with or without a signed release, unless explicit permission of either the Executive Director or Clinical Director has been obtained.
- **Court Orders:** Courts are empowered to authorize disclosure that would otherwise be prohibited. Any time a Court Order requires disclosure of client charts, the Executive Director or Clinical Director must review the Order and, if deemed necessary, contact an attorney before disclosing such information.
- **Written Consent to Release:** The Consent for Release/Receive Confidential Information (for number Clinical-172) must be utilized if any information about a client is released to any outside individual or agency. Albuquerque Behavioral Health, LLC personnel may reuse to release information if the disclosure would be damaging to the client, with the agreement of the Clinical Director or Executive Director. Use of the Consent for Release/Receive Confidential Information must meet the following conditions:
 - The client must be informed of the reasons for the disclosure and must be provided with a description of the types of information to be released;
 - The client must be informed of the person or agency to whom the information will be released;

ALBUQUERQUE BEHAVIORAL HEALTH CLINICAL POLICIES AND PROCEDURES

Policy Number: 2106

Effective Date: 4-1-06

Revision Date: N/A

Subject: Confidentiality and Client Charts

- The client must be given the right to refuse to release information, and the release form must specify the likely consequences or probable outcome of refusal to release the information. The consent must be given freely and voluntarily. Generally, treatment cannot be denied if the client refuses to sign a release unless such refusal is likely to impede or undermine treatment. Albuquerque Behavioral Health, LLC (i.e., a client is receiving treatment from another agency or therapist, refuses to divulge details of previous treatment when that information is necessary to complete a thorough evaluation, etc).
- Further disclosure (by the receiving party) is prohibited without specific written consent from the client.

- After written consent has been obtained, disclosure may be made to any individual(s) when such disclosure is fully understood by the client, and when such disclosure is in the best interest of the client.

The guiding principle underlying any disclosure must be in the best interests of the client.

Chart Security

- Clinical charts are legal documents and are to be treated as such.
- Documentation containing any information pertaining to clients shall be kept in a locked filing cabinet or other similar container when not in actual use. **Documents containing the names of clients must never be left on the clinician's desk or pinned to a bulletin board where other individuals might see the information.**
- Client charts may not be removed from the office except when used for inter-agency case conferences or consultations, or unless required by court order.
- Closed charts must be stored for the period required by law (see Chart Policy). Closed charts may be used in cases of re-admission provided the statutory storage period has not elapsed. After the statutory storage period has elapsed, charts must be destroyed in a manner that insures confidentiality.
- All former staff members and volunteers are required by law to maintain complete confidentiality of client information.
- When a Subpoena or Subpoena Duces Tecum is issued for a chart, the matter will be handled on a case-by-case basis through consultation with the Executive Director.
- The Master Schedule Book and any other charts or documents indicating client names must be securely locked at night.



ALBUQUERQUE
City of Albuquerque

Request for Supplier Information

Substitute Form **W9**

Department of Finance and
Administrative Services

SECTION 1: CONTACT INFORMATION AND TAXPAYER IDENTIFICATION NUMBER

NAME (as shown on your income tax return). Name is required on this line; do not leave this line blank.

Albuquerque Health Services LLC dba/ Albuquerque Behavioral Health

BUSINESS NAME/ disregarded entity name, if different from above.

PRIMARY ADDRESS (number, street, and apt or suite no)

8200 Mountain Rd NE Suite 106

REMITTANCE ADDRESS (number, street, and apt or suite no)

8200 Mountain Rd NE Suite 106

CITY, STATE, and ZIP CODE

Alb NM 87110

REMITTANCE CITY, STATE, and ZIP CODE

Alb NM 87110

PHONE

505-304-2473 cell 505-830-6500 office

EMAIL ADDRESS

bobbiea @ abqbh.com

SOCIAL SECURITY NUMBER

OR

EMPLOYER IDENTIFICATION NUMBER

New Mexico CRS TAX ID (if applicable)

- -

TAX CLASSIFICATION (check only one)

☒ INDIVIDUAL/SOLE PROPRIETOR or single-member LLC

☐ C CORPORATION

☐ S CORPORATION

☐ PARTNERSHIP

☐ TRUST/ESTATE

☐ LIMITED LIABILITY COMPANY— Enter the tax classification (C=C Corporation, S=S Corporation, P=Partnership)

Note: For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ 501(C)3/NON-PROFIT ORGANIZATION

☐ OTHER (SEE INSTRUCTIONS)

EXEMPTIONS (codes apply to certain entities, not individuals; see instructions)

EXEMPT PAYEE CODE (if any)

EXEMPTION FROM FATCA REPORTING CODE (if any)

SECTION 2: BUSINESS DEMOGRAPHICS (CHECK ALL THAT APPLY)

☒ **Local Business** - Headquartered and maintains its principal office and place of business within the Greater Albuquerque Metropolitan Area (City of Albuquerque or Bernalillo County).

☐ **Doing Business Locally** - Either not headquartered or does not maintain its principal office and place of business here, but maintains a storefront in the Greater Albuquerque Metropolitan Area and employs one or more City of Albuquerque or Bernalillo County residents.

☒ **Woman Owned Business** - At least 51% owned and controlled by one or more women, in the case of a publicly-owned business, at least 51% of the stock of which is owned by one or more women.

☐ **Minority Business Enterprise (MBE) Owned** - At least 51% owned and controlled by one or more racial/ethnic minorities or, in the case of a publicly-owned business, at least 51% of the stock of which is owned by one or more racial/ethnic minorities. Please specify the race/ethnicity of minority owners (question to the right).

☐ **LGBTQ+ Owned Business** - At least 51% owned and controlled by one or more LGBTQ+ individuals, in the case of a publicly-owned business, at least 51% of the stock of which is owned by one or more LGBTQ+ individuals.

☐ **None of the Above Categories Apply**

If your business is MBE-owned, please specify the race/ethnicity of minority owner(s). Check all that apply:

☐ Hispanic American

☐ Native American

☐ Black or African American

☐ Asian-Indian American

☐ Asian-Pacific American

SECTION 3: PURCHASE ORDERS (COMPLETE ONLY IF YOU ACCEPT POs)

ELECTRONIC POs AND INVOICES (select one)

☐ Transcepta (preferred method)

☐ Email

PO CONTACT INFORMATION

FULL NAME

EMAIL ADDRESS

SECTION 4: CERTIFICATION

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
- I am a U.S. citizen or other U.S. person (defined in the instructions); and
- The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification Instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN.

The Internal Revenue Service does not require your consent to any provision on this document other than the certifications required to avoid backup withholding.

SIGNATURE of U.S. person

B. Anderson

DATE

4/18/22

PRINT NAME

Bobbie Anderson

TITLE

owner

ALBUQUERQUE BEHAVIORAL HEALTH POLICIES AND PROCEDURES

Policy Number: 1103	Effective Date: April, 2006	Revision Date: N/A
Subject: Staff Member Personnel Policy - Drugs/Alcohol Use		
<p>POLICY:</p> <p>As a mental health and substance abuse facility, staff members are expected to act as role models. Strict adherence to this drug/alcohol use policy is imperative in order to re-enforce the purpose and goals of Albuquerque Behavioral Health, LLC.</p> <p>The following describes Albuquerque Behavioral Health, LLC stance with regard to drug/alcohol use:</p> <ul style="list-style-type: none">• <i>On The Job (including lunches and breaks):</i> While on the job, on or off the premises, the use or possession of alcohol is prohibited. Likewise, the possession, sale or distribution of illegal drugs is also prohibited. Working under the influence of illegal drugs and/or alcohol may be considered grounds for termination.• <i>Legal Mood-Altering Substances Prescribed By A Physician For Health Reasons:</i> These substances may alter a staff member's performance. Therefore, a staff member taking mood-altering substances prescribed by a physician must advise his or her immediate supervisor.• <i>Off the Job:</i> During off-duty time, the use of alcohol or other mood-altering substances which may adversely affect a staff member's job performance or the public perception of Albuquerque Behavioral Health, LLC is strongly discouraged.• <i>Convictions:</i> Any conviction for the distribution or sale of illegal substances may be considered grounds for termination. Situations that merit reasonable suspicion will be turned over to the appropriate authorities. <p>Failure to comply with this policy may result in disciplinary action up to and including dismissal.</p>		

Staff member signature

Date

Supervisor's signature

Date

ALBUQUERQUE BEHAVIORAL HEALTH CLINICAL POLICIES AND PROCEDURES

Policy Number: 2256.5	Effective Date: 6-9-08	Revision Date: N/A
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Subject: Supervision of Lower level licensed staff therapists

POLICY:

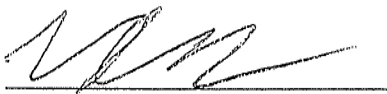
The following policy describes supervision requirements of lower level licensed therapists.

Other Corresponding Policies:

- Clinical Hiring Requirements
- Staff Member Personnel Policies
- Supervision

PROCEDURE:

1. In order to provide therapeutic services for ABH clients the staff member must at least hold valid state of New Mexico a license as an LPC, LMHC, LMSW and/or an addiction alcohol and/or drug counselor.
2. The licensed LPC, LMHC, LMSW and/or an addiction alcohol and/or drug counselor must be supervised by a licensed psychologist, psychiatrist, counselor (LPCC), or social worker (LISW).
3. Supervisors must have at least the CEU (three hours) credits, required by the New Mexico Counseling and Therapy Practice Board.
4. Lower level licensed therapists are assigned a supervisor during the initial employee orientation.
5. Supervisors formally supervise, with documentation, lower level licensed therapists at least once a week for one hour and must be available for emergency, crisis or immediate consults.
6. Lower level licensed therapists are required to attend weekly treatment team meetings.



ALBUQUERQUE BEHAVIORAL HEALTH, LLC

CLINICAL POLICIES AND PROCEDURES

Policy Number: 2259	Effective Date: 3/01/09	Revision Date: 12/16/09
Subject: Clinical Supervision		
<p>POLICY:</p> <p>The clinical supervisor must :</p> <ol style="list-style-type: none"> 1. Review and sign the individualized treatment plan within two weeks of completion to ensure clinical oversight of the treatment process. 2. Read and review the progress notes and document monthly. 3. Provide staff consultation and document monthly. 4. Provide supervision for therapist as needed. <p>Clinical supervision must follow the requirements of the New Mexico Counseling, Therapy and practice board, part 19.</p> <p>Supervision serves as a stable source of support, encouragement and direction in treatment planning, problem solving and record keeping.</p> <p>A clinical supervisor is defined as "an individual, who by experience, training and /or level of licensure is able to provide supervision to clinicians regarding the appropriate care and treatment of substance abusing" and co- occurring disorders clients. Supervision includes, but is not limited to: oversight of treatment plan and construction, oversight of client progress notes and other written clinical records; provision of consultation to assist treatment counselors in best practices in working with their clients.</p> <p>Oversight of treatment planning:</p> <ol style="list-style-type: none"> 1. The supervisor provides significant input into treatment plans and helps to establish targets for behavior change. 2. The supervisor reviews and signs the treatment plan within two weeks of completion to ensure clinical oversight of the treatment process. <p>Oversight of progress notes:</p> <ol style="list-style-type: none"> 1. The clinical supervisor reads and reviews progress notes and documents bi-weekly to ensure clinical oversight of the treatment process in clients' progress notes. <p>Staff Consultation</p> <ol style="list-style-type: none"> 1. The supervisor provides staff consultation at least bi-monthly and documents bi-monthly to ensure oversight to the treatment process through staff consultation 		

Group Schedule

Monday

4p Anger Management

5p parenting

5p Out-Patient Substance Abuse training (OSAT)

Tuesday

4p Relapse Prevention (RP)

5p Women's OSAT

5p Men's OSAT

6p RP

Wednesday

4p RP

5p DBT Skills

5p OSAT

6p OSAT

Thursday

4p RP

5p OSAT

Friday

9a co-occurring

1p RP

6p MRT

6p RP

Saturday

10a OSAT

May 31, 2018

Provider Enrollment/Credentialing
ALBUQUERQUE BEHAVIORAL HEALTH
8200 MOUNTAIN RD NE
100
ALBUQUERQUE NM 87110-7835

RE: Provider # 13736019 FEIN/SSN #824810528
Provider Type/Specialty: 435
NPI # 1285137034 Provider Type 435

Dear Provider:

We would like to take this opportunity to welcome you to the New Mexico Medicaid Program. Your provider number is 13736019, and the date of your enrollment is effective from 06/01/2018. Your Medicaid provider enrollment period ends when your current license expires. To keep your provider number active and current, please submit a copy of your license prior to the expiration date. The license should be submitted to the following address. If your provider name, address, telephone number, professional license, certification, board specialty, corporate name, corporate ownership, or any other information you supplied on your provider participation agreement changes, please notify us in writing at the following address. Providers are required to notify us at the address below as soon as possible, but at least 60 days prior to a change of ownership.

Attn: Provider Enrollment
Conduent
New Mexico Medicaid Project
P.O. Box 27460
Albuquerque, NM 87125-7460

If you have any questions about your enrollment or participation in the New Mexico Medicaid Program, please contact the Provider Enrollment Unit. Call center staff are available to answer your questions between the hours of 8:00 AM to 4:00 PM Monday through Friday at 1-800-299-7304 or 505-246-9988.

Only claims with service dates on or after the effective enrollment date can be accepted for processing. All claims must be received by Conduent within 90 days from the date of this notice and within 210 days of the date of service. If you are not yet approved to bill electronically submit the claims on paper and attach a copy of this letter to each claim to meet the filing limit. Contact Conduent New Mexico Medicaid Project HIPAA Helpdesk at 505-246-0710 or 1-800-299-7304 to set up electronic billing for future claims. For proper identification and payment, all claims must be billed with the complete provider name and identification number.

You have 90 days from the date of this letter to submit those claims, unless you provided services on the basis of an individualized education plan or an

individualized family service plan through a school or if the service was provided by an Indian Health Service facility or Tribal 638 operated facility. School based services must submit claims within 120 days from the date of this notice, not to exceed 210 days from the date of service. IHS/Tribal 638 must submit claims to the fiscal agent within the Federal filing limit of two years.

Claims must be billed using the complete provider name and the provider's NPI, unless the provider is an 'atypical' provider who is exempt from obtaining an NPI in which case the assigned provider number should be used.

If the provider has more than one location under the same NPI, the claim must also include the billing provider ZIP code (+4) which must be the ZIP (+4) for the physical location which matches the Medicaid ID for that location. If the provider has more than one line of business associated with the same NPI, taxonomy must also be submitted on the claim whenever the NPI is used for the billing and rendering providers.

Please familiarize yourself with the Medical Assistance Division Program Manual and Billing Instructions specific to the service you provide. These documents are available on the New Mexico Medical Assistance Division's website at <http://www.hsd.state.nm.us/mad/providerpackets/index.html>. The documents contain information about covered services, service limitations, services that are not covered under the program, and also services that require prior approval. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided, and to comply with the requirements.

New Mexico Medicaid requires Electronic billing and Electronic Funds Transfer (EFT) payment method. [2/1/95; 8.302.2.9 NMIC - Rn, 8 NMIC 4.MAD. 702, 5/1/04; A, 5/1/10]. For more information about these policies please refer to the HSD website: <http://www.hsd.state.nm.us/mad>. Please register on the New Mexico Medicaid Web Portal at <https://nmmedicaid.acs-inc.com> or contact Conduent New Mexico Medicaid Project Provider Helpdesk at 505-246-0710 or 800-299-7304.

Conduent New Mexico Medicaid Project Provider Relations call center staff is available to answer your questions Monday, Tuesday, Wednesday and Friday between the hours of 8:00 AM to 5:00 PM and Thursday 8:00 AM to 4:00 PM at 505-246-0710 or 800-299-7304.

Sincerely
Conduent
New Mexico Medicaid Project
Provider Enrollment

Medicare
Western Sky
Agreement

PARTICIPATING PROVIDER AGREEMENT

This Participating Provider Agreement (together with all Attachments and amendments, this "Agreement") is made and entered by and between Albuquerque Health Services, LLC, DBA Albuquerque Behavioral Health ("Provider") and Western Sky Community Care, Inc. ("Health Plan") (each a "Party" and collectively the "Parties"). This Agreement is effective as of the date designated by Health Plan on the signature page of this Agreement ("Effective Date").

WHEREAS, Provider desires to provide certain health care services to individuals in products offered by or available from or through a Company or Payor (as hereafter defined), and Provider desires to participate in such products as a Participating Provider (as defined herein), all as hereinafter set forth.

WHEREAS, Health Plan desires for Provider to provide such health care services to individuals in such products, and Health Plan desires to have Provider participate in certain of such products as a Participating Provider, all as hereinafter set forth.

NOW, THEREFORE, in consideration of the recitals and mutual promises herein stated, the Parties hereby agree to the provisions set forth below.

ARTICLE I - DEFINITIONS

When appearing with initial capital letters in this Agreement (including an Attachment), the following quoted and underlined terms (and the plural thereof, when appropriate) have the meanings set forth below.

- 1.1. "Affiliate" means a person or entity directly or indirectly controlling, controlled by, or under common control with Health Plan.
- 1.2. "Attachment" means any document, including an addendum, schedule or exhibit, attached to this Agreement as of the Effective Date or that becomes attached pursuant to Section 2.2 or Section 8.7, all of which are incorporated herein by reference and may be amended from time to time as provided in this Agreement.
- 1.3. "Clean Claim" has, as to each particular Product, the meaning set forth in the applicable Product Attachment or, if no such definition exists, the Provider Manual.
- 1.4. "Company" means, as appropriate in the context, Health Plan and/or one or more of its Affiliates, except those specifically excluded by Health Plan.
- 1.5. "Compensation Schedule" means at any given time the then effective schedule(s) of maximum rates applicable to a particular Product under which Provider and Contracted Providers will be compensated for the provision of Covered Services to Covered Persons. Such Compensation Schedule(s) will be set forth or described in one or more Attachments to this Agreement, and may be included within a Product Attachment.
- 1.6. "Contracted Provider" means a physician, hospital, health care professional or any other provider of items or services that is employed by or has a contractual relationship with Provider. The term "Contracted Provider" includes Provider for those Covered Services provided by Provider.
- 1.7. "Coverage Agreement" means any agreement, program or certificate entered into, issued or agreed to by Company or Payor, under which Company or Payor furnishes administrative services or other services in support of a health care program for an individual or group of individuals, and which may include access to one or more of Company's provider networks or vendor arrangements, except those excluded by Health Plan.



BlueCross BlueShield of New Mexico

August 27, 2018

ALBUQUERQUE BEHAVIORAL HEALTH
8200 MOUNTAIN RD NE, STE 100
ALBUQUERQUE, NM 87110

Hello,

We are pleased that you continue to be a Participating Provider with Blue Cross and Blue Shield of New Mexico. Enclosed please find a copy of your Centennial Care 2.0 New Mexico Medicaid Amendment Agreement with the effective date of January 01, 2019 for your records.

The current *Blues Provider Reference Manual* is available to you on our website at bcbsnm.com. If you do not have online access, call Network Services and a copy of the manual on a flash drive will be mailed to your office. Examples of other online resources include the Provider Finder[®], drug list information, medical policy information, the *Blue Review* provider newsletter, electronic claims filing information, and provider forms.

We look forward to continuing our work with you and your staff. Should you have any questions, feel free to contact your Network Services Provider Representative at 505-837-8800, or outside of Albuquerque at 1-800-567-8540.

Sincerely,

Network Services Department
Blue Cross and Blue Shield of New Mexico

Blue Cross Community CentennialSM • P.O. Box 27838 • Albuquerque, NM 87125-7838 • 1-866-689-1523 • bcbsnm.com

Such services are funded in part with the State of New Mexico.

Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

472634385

Magellan

August 13, 2018

**00063

BOBBIE J ANDERSON
7924 WILLIAM MOYERS AVE, NE
ALBUQUERQUE, NM 87122-2739

Dear BOBBIE J ANDERSON:

MIS #: 600915962

Magellan Healthcare* has completed the required verification of your credentialing application and supporting materials, and the Magellan Credentialing Committee has approved you for network participation.

However, note that completion of the credentialing process does not mean that you are eligible to see Magellan members as an in-network provider yet.

Please do not accept Magellan members for treatment unless:

- You have been notified that your individual contract was executed, or
- Your group administrator has been notified that the contract for the group with which you are affiliated was executed.

Also note that if you or your group administrator has not yet signed up for electronic funds transfer (EFT) for payment, please do so immediately to prevent any delay in the processing of the contract.

If you have any questions or concerns, please contact Provider Services. Providers servicing Medicaid beneficiaries in Florida (under Magellan Complete Care of Florida) may call 800-327-8613; all others please call 800-788-4005.

Sincerely,

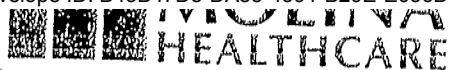
Magellan Credentialing Department

*Magellan Healthcare, Inc. f/k/a Magellan Behavioral Health, Inc.; Florida MHS, Inc.; Merit Behavioral Care; Magellan Health Services of Arizona, Inc.; Magellan Behavioral Health of Florida, Inc.; Magellan Behavioral of Michigan, Inc.; Magellan Behavioral Health of New Jersey, LLC; Magellan Behavioral Health of Pennsylvania, Inc.; Magellan Providers of Texas, Inc.; Human Affairs International of California, Inc.; Magellan Health Services of California, Inc. - Employer Services, and their respective affiliates and subsidiaries are all affiliates of Magellan Health, Inc. (collectively "Magellan").



CredRecred Letter

600915962045593101217 COM



Dear Contract Administrator:

You have been approved by our Provider Interest Committee to become an in-network provider with Molina Healthcare of New Mexico, Inc.; therefore I have attached the Provider Services Agreement with Molina Healthcare of New Mexico, Inc.

As an integral part of this Agreement, please refer to the Provider Manual; a link has been provided on page 27 of the Agreement and is also below:

http://www.molinahealthcare.com/providers/nm/medicaid/manual/Pages/provider_manual.aspx

After your review, if you agree to the terms in the agreement, please:

- Please review all information on page 13; *email any changes before you print the contract*
- Print two (2) full copies of the attached agreement
- Sign pages one (1) and twenty seven (27) of both copies
- Return both copies of the contract with your original signature pages included to MHNM

Please do not fill in the effective date on the second page of the document. It is intentionally left blank. An effective date will be assigned by MHNM once the configuration of the contract is done in the operations system at the health plan.

There should be a total of four (4) signed pages that you will be returning to Molina. If all signature pages are not signed, we will not be able to execute the Agreement. The mailing address is listed below:

Molina Healthcare of New Mexico
Attn: Clara Bulger
8801 Horizon Blvd. N.E
Albuquerque, New Mexico 87113

We cannot accept faxes or photocopies; all four (4) signatures must be original. We will execute the Agreement and return one to you for your files.

I look forward to receiving the signed agreement. If you should have any questions, please feel free to contact me at (505) 348-0385 or email me at clara.bulger@molinahealthcare.com.

Sincerely,

Clara Bulger

Clara Bulger
Contract Specialist
Molina Healthcare of New Mexico

Molina Healthcare of New Mexico • 8801 Horizon Blvd NE, Albuquerque, NM 87113
Phone: 505-342-4660 • www.MolinaHealthcare.com

INDIVIDUAL PROVIDER ADDENDUM

Aetna

The undersigned health care provider ("Provider"), a member of Albuquerque Behavioral Health ("Entity"), has and does hereby designate Entity as his/her attorney-in-fact for the purposes of negotiating, consenting to and executing the Behavioral Health Provider Group Agreement (the "Agreement"), between Aetna Health Management, LLC, a Delaware limited liability company ("Company") and Entity and any documents related to amendments to the Agreement. Terms capitalized herein but not otherwise defined shall have the meanings ascribed to them in the Agreement.

Provider hereby acknowledges that Provider has reviewed the Agreement (a copy of which has been made available to Provider by Entity), under which Entity, on behalf of Provider, agrees to provide Covered Services to Members enrolled in the Plans. Plans include any health benefit product or plan issued, administered, or serviced by Company or one of its Affiliates, including, but not limited to, HMO, preferred provider organization, indemnity, Medicaid, Medicare and Worker's Compensation. Provider hereby agrees to be bound by the terms and conditions of the Agreement, including, without limitation, compliance with the Participation Criteria applicable to Provider and all applicable Company rules, policies and procedures.

Provider hereby agrees to seek compensation solely from Entity for services rendered to Members under the terms of the Agreement, and shall in no event bill Company, its Affiliates, Payors, or Members for any such services (except for any Copayments, Coinsurance or Deductibles Members may be required to pay for certain Covered Services). Provider shall hold Company, its Affiliates, payors and Members harmless against any and all claims related to or arising out of payment for Covered Services rendered to Members for which Entity is financially responsible, when a Payor has remitted payment to Entity and said claim alleged that Entity has failed to remit payment to providers. Provider further agrees that if the Member is enrolled in an HMO, then in no event, including but not limited to non-payment by the HMO, insolvency of the HMO or breach by the HMO of the Agreement, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Member or persons acting on Member's behalf for Covered Services. This provision shall not prohibit collection of Copayments, Coinsurance or Deductibles. Provider further agrees that this provision shall be construed for the benefit of Members, shall supersede any oral or written agreement to the contrary now existing or hereafter entered into between Provider or Entity and a Member or any person acting on behalf of a Member, and shall survive the termination of the Agreement, regardless of the cause giving rise to termination.

Provider hereby agrees that in the event: (i) Provider ceases to be a member of Entity; (ii) the Agreement expires or is terminated for any reason; (iii) the Entity is dissolved; (iv) a voluntary or involuntary bankruptcy or a proposed settlement of outstanding debts under applicable reorganization or insolvency laws is filed by or against Entity, a receiver is appointed or Entity makes an assignment for the benefit of creditors; or (v) the Entity otherwise ceases to exist, either voluntarily or involuntarily (each, a "Triggering Event"), the terms of the Agreement shall, at Company's option, survive with respect to Provider for the first nine (9) months after such Triggering Event, in which case Provider shall continue to provide services to Members in accordance with the terms of the Agreement during said nine (9) month period. Provider agrees to take any and all actions necessary to effectuate the intent of this paragraph, including executing an individual agreement for participation in Company's provider network if so requested by Company.

IN WITNESS WHEREOF, the undersigned has executed this Individual Provider Addendum as of this ____ day of _____, 20__, intending to be legally bound hereby.

PROVIDER

By: Bobbie AndersonPrinted Name: Bobbie AndersonFEDERAL TAX I.D. NUMBER: 82-4810528

COMPANY

By: Albuquerque Behavioral Health

Printed Name: _____

Albuquerque Behavioral Health

Fee and sliding scale

- Individual counseling: \$65.00 per one hour session.
- Couples counseling: \$75.00 per one hour session.
- Family counseling: \$75.00 per one hour session.
- Group counseling: \$35.00 per one hour session.

Sliding scales start at a minimum of \$60.00 per individual, family or couples counseling for those at \$30,000 per year for one to 50,000 for a family of eight. Adjustments are also reduced based on the number of services. Maximum allowable fee is \$75.00 per session.

Group scales are a minimum of \$25.00 per 1-hour group to the full \$35.00 per group session.

Albuquerque Behavioral Health agrees to charge the required fee by the City contract.

Albuquerque Behavioral Health (ABH)**Consent for Telephone and Telehealth Services for COVID 19**

I understand that I am being offered telephone and/or telehealth (video) services for behavioral health counseling due to the COVID-19 crisis. Further, I understand that I can choose either one of these under current COVID-19 guidelines in New Mexico. In general, the following are the conditions I am agreeing to:

- Counseling for Group/Individual Sessions will be conducted via telephone and/or video service (such as Google Meets, Teledoc & ZOOM).
- The benefits are safer access to care under social distancing guidelines and it allows my participation from a location of my choice (as long as I am in the state of New Mexico). I agree to not engage in telephone or telehealth services with ABH if I am not in New Mexico.
- There are potential risks to this technology—including interruptions, unauthorized access, and technical difficulties. I understand that I can discontinue the telehealth sessions if it is felt that the videoconferencing connections are not adequate for the situation. I agree to notify ABH if I decide to discontinue services.
- I understand that my insurance coverage may not guarantee payment of telehealth services and that fees are my responsibility if my insurance or funding source doesn't pay.
- If I choose telephone services, I understand that I am responsible for any charges/fees from my phone service.
- I agree that neither I nor my counselor will record our telephone or telehealth sessions.
- We both agree to keep all information confidential except as guided by confidentiality regulations. I understand that my counselor will keep information confidential as much as possible according to HIPPA guidelines—I also understand and agree that HIPPA guidelines have been waived during the COVID-19 crisis.
- I understand that my counselor may need to call authorities in the event of emergency during our session.

CONSENT TO USE THE TELEHEALTH (VIDEO SERVICES BY Telephonic Measures)

Telehealth by Google Meets, Teledoc, & Zoom is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use, has a unique meeting ID, and has a password for security. By signing this document, I acknowledge:

1. Telehealth by Video/Phone is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Video/Phone facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care. Video/Phone may experience connectivity issues and I understand that my counselor is not responsible for these.
3. I agree to familiarize myself with the Video/Phone so that I am an informed consumer.
4. To maintain confidentiality, I will not share my telehealth appointment link or password with anyone unauthorized to attend the appointment. I will make an arrangement with my counselor to receive the meeting ID and password in a secure manner.
5. I agree to reconnect with my counselor by phone in the event that Video/Phone cannot provide or cannot maintain the telehealth service. If there is an interruption, you must get back onto the call or video as the group sessions may not be able to be interrupted as the individual session may have a call back if available. Call the office at 505-830-6500-**IN CASE OF AN EMERGENCY—I agree that I will do the following if I cannot reach my counselor:**
Call New Mexico Crisis and Access Line (NMCAL) - 855-662-7477, Call Agora Crisis Center - 855-505-4505, 505-277-3013, 800-273-TALK, Call 911, or go to the nearest emergency room

By signing this form, I certify that 1) I have read the form, 2) that I understand the information including the risks and benefits of telephone and/or telehealth services, 3) that I have had opportunity to ask questions and that these have been answered to my satisfaction.



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

03/16/2022

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Alpha & Omega 1387 S Gilbert Road Ste 106-505 Gilbert, AZ 85295	CONTACT NAME: Shauna Murphy PHONE (A/C, No, Ext): 480 792 1000 FAX (A/C, No): 480-792-6797 E-MAIL ADDRESS: shauna@alphaomega.com <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: center;">INSURER(S) AFFORDING COVERAGE</th> <th style="text-align: center;">NAIC #</th> </tr> <tr> <td>INSURER A: SENTINEL INS CO LTD</td> <td>11080</td> </tr> <tr> <td>INSURER B:</td> <td></td> </tr> <tr> <td>INSURER C:</td> <td></td> </tr> <tr> <td>INSURER D:</td> <td></td> </tr> <tr> <td>INSURER E:</td> <td></td> </tr> <tr> <td>INSURER F:</td> <td></td> </tr> </table>	INSURER(S) AFFORDING COVERAGE	NAIC #	INSURER A: SENTINEL INS CO LTD	11080	INSURER B:		INSURER C:		INSURER D:		INSURER E:		INSURER F:	
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INSURER D:															
INSURER E:															
INSURER F:															
INSURED Albuquerque Health Services LLC dba Albuquerque Behavioral Health 8200 Mountain Rd NE Ste 100 Albuquerque, NM 87110-7835															

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS												
	COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER <input type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC OTHER:						EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COMPROP AGG \$ \$												
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$												
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE GED RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$ \$												
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N	N/A	59WFCAB4N2G	04/16/2022	04/16/2023	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 5%;">PER STATUTE</th> <th style="width: 5%;">OTHER</th> <th style="width: 45%;">E L EACH ACCIDENT</th> <th style="width: 45%;">\$ 500,000</th> </tr> <tr> <td></td> <td></td> <td>E L DISEASE - EA EMPLOYEE</td> <td>\$ 500,000</td> </tr> <tr> <td></td> <td></td> <td>E L DISEASE - POLICY LIMIT</td> <td>\$ 500,000</td> </tr> </table>	PER STATUTE	OTHER	E L EACH ACCIDENT	\$ 500,000			E L DISEASE - EA EMPLOYEE	\$ 500,000			E L DISEASE - POLICY LIMIT	\$ 500,000
PER STATUTE	OTHER	E L EACH ACCIDENT	\$ 500,000																
		E L DISEASE - EA EMPLOYEE	\$ 500,000																
		E L DISEASE - POLICY LIMIT	\$ 500,000																

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Out-patient Counseling Services

City of Albuquerque
 Risk Management
 PO BOX 1293
 Albuquerque, NM 87103
 Is listed as additional insured

CERTIFICATE HOLDER City of Albuquerque Risk Management PO BOX 1293 Albuquerque, NM 87103	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE Shauna Murphy
---	--



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

03/01/2022

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Hiscox Inc. 520 Madison Avenue 32nd Floor New York, New York 10022	CONTACT NAME: PHONE (A/C, No, Ext): (888) 202-3007 FAX (A/C, No): E-MAIL ADDRESS: contact@hiscox.com INSURER(S) AFFORDING COVERAGE INSURER A: Hiscox Insurance Company Inc NAIC #: 10200 INSURER B: INSURER C: INSURER D: INSURER E: INSURER F:
INSURED ALBUQUERQUE HEALTH SERVICES, LLC DBA ABH DBA ABH 8200 MOUNTAIN RD NE SUITE 100 ALBUQUERQUE, NM 87110	

COVERAGES

CERTIFICATE NUMBER:

REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS MADE <input checked="" type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC <input type="checkbox"/> OTHER	Y		P100.209.995.3	04/15/2022	04/15/2023	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000 MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
	UMBRELLA LIAB EXCESS LIAB DED RETENTION \$						OCCUR CLAIMS-MADE EACH OCCURRENCE \$ AGGREGATE \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below						Y/N N/A
A	Professional Liability	Y		P100.209.163.3	04/15/2022	04/15/2023	Each Claim: \$ 1,000,000 Aggregate: \$ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Out-patient Counseling Services. City of Albuquerque / Risk Management. PO BOX 1293. Albuquerque NM 87103 / Listed as additional Insured

CERTIFICATE HOLDER

City of Albuquerque / Risk Management
 PO BOX 1293
 Albuquerque, NM 87103

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

**City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division**

INSURANCE WAIVER REQUEST

Agency/Organization: Albuquerque Health Services LLC dba/Albuquerque Behavioral Health

Typed Name of Authorized Official of the Agency: Bobbie Anderson

Title: Owner/Executive Director

Signature: Bobbie Anderson Date: 4/18/22

Contractor requests the following insurance be waived. Please check **all** that apply and sign associated certifications.

☐ A. Commercial General Liability Insurance ("CGL")

Please provide an explanation for why you believe this insurance should be waived for your agency:

Signature: _____ Date: _____

☒ X-B. Commercial Automobile Liability Insurance ("CAL")

I hereby certify that neither I, nor employees or contractors employed by this agency, use vehicles in other than a commuting capacity. I further certify that should I, or any employees or contractors employed by this agency, use vehicles in any manner other than a commuting capacity, the agency will comply with the City of Albuquerque's Automobile Insurance requirements.

Signature: Bobbie Anderson Date: 4/18/22

☐ C. Workers' Compensation Insurance

I hereby certify that I employ fewer than three employees and am, therefore, not subject to the provisions of the Workers' Compensation Act of the State of New Mexico. I further certify that should I employ three or more persons during the term of my contract with the City, I will comply with the provisions of the New Mexico Workers' Compensation Act and provide proof of such compliance to the City of Albuquerque.

Signature: _____ Date: _____

**City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division**

☐ **D. Professional Liability (Errors and Omissions) Insurance**

Please provide an explanation for why you believe this insurance should be waived for your agency:

☒ **X-E. Sexual Abuse Molestation Coverage:**

I hereby certify that neither I, nor employees or contractors employed by this agency, will have unsupervised or one-on-one contact with children or compromised adults. I further certify that should I, or any employees or contractors employed by this agency, have unsupervised or one-on-one contact with children or compromised adults, the agency will comply with the City of Albuquerque's Sexual Abuse Molestation Coverage Insurance requirements.

Signature: *Bobbie Anderson* Date: 4/18/22

☐ **X-F. Cyber Liability Coverage**

I hereby certify that neither I, nor employees or contractors employed by this agency, will have cybernetic access to the City's confidential information, taxpayer data, information technology, personnel, healthcare, accounting, or finance systems. I further certify that should I, or any employees or contractors employed by this agency, have cybernetic access to the City's confidential information, taxpayer data, information technology, personnel, healthcare, accounting, or finance systems, the agency will comply with the City of Albuquerque's Cyber Liability Coverage Insurance requirements.

Signature: *Bobbie Anderson* Date: 4/18/22

For City of Albuquerque Use Only:

Insurance Waiver Approved:

DocuSigned by:
By: *Jeannette Chavez, Risk Manager*
6393AC1BB5C845E...

Title: Risk Manager

Date: 6/29/2022 | 9:45 AM MDT

From: Chavez, Jeannette L. <jeannettechavez@cabq.gov>
Sent: Thursday, June 30, 2022 12:11 PM
To: Padilla, Jeanne C. <jcpadilla@cabq.gov>
Subject: RE: ABH CGL

Yes, this is fine.



JEANNETTE CHAVEZ

risk manager

she/her

o 505.768.3263

cabq.gov

From: Padilla, Jeanne C. <jcpadilla@cabq.gov>
Sent: Thursday, June 30, 2022 12:05 PM
To: Chavez, Jeannette L. <jeannettechavez@cabq.gov>
Subject: ABH CGL

Hi Jeannette:

You have already approved the ins waiver for Albuquerque Behavioral Health's FY-23 contact, however this is a follow up email specific to their CGL.

Is it acceptable that they carry \$1M per occurrence, instead of \$2M per occurrence?

I have attached their COI.

Thank you.

Jeanné

Requester: E26511**Status:** Pending Approval**Requested By:** Chavez, Monique B**Currency:** USD**Entered Date:** 8/2/22**Requisition Total:** 100,000.00**Requisition Type:** PT or PT Types**Source Next Yr:****Blanket Exp Date:**

Line: 1 **Desc:** FY23 ABQ Behavioral Health **Quantity:** 1.0000 **UOM:** EA **Price:** 100,000.00 **Line Total:** 100,000.00
Supplier: ALBUQUERQUE HEALTH SERVICES LLC **Category:** 918-03 Alcohol and Drug Abuse Consult

Buyer ID: E31190 **Buyer Name:** Chavez, Monica J**Cert Source:** COA **Class:** LOCAL**Line Comments:****Amt Only Flg:** N

<<CCN20220145, SUPPLIER ID# 0000115517, TERM:07/1/22-06/30/23, CONTACT- Monique Chavez (moniquechavez@cabq.gov)

ATTENTION PURCHASING Please create new POR.>>

Ship Line: 1 **Ship To:** 10021 **Address:** **Shipping Quantity:** 1.0000
Attention: Chavez, Monique B **Due Date:** 7/1/22 FC-Administration **Shipping Total:** 100,000.00
Ship Via: COMMON **Freight Terms:** DES 400 Marquette NW
Room 504
Albuquerque NM 87102

Dist	Status	Qty	PCT	Amount	GL Unit	Account	Fund	Dept
1	Open	1.0000	100.00	100,000.00	ABQ01	520500	110	2923812

Capitalize

N