ORIGINAL

COUNTY OF SHASTA
OFFICE OF AUDITOR-CONTROLLER
REPORT OF CLAIMS REQUIRING BOARD ACTION IN ORDER TO
AUTHORIZE PAYMENT BY AUDITOR-CONTROLLER
6/27/2017

FUND/DEPT/ACCT	DEPARTMENT	PAYEE	DESCRIPTION	Amount	REASON	DEPARTMENT'S EXPLANATION
40401/799390	MENTAL HEALTH	MOUNTAIN VALLEYS HEALTH CENTERS INC	OUTPATIENT MENTAL HEALTH SERVICES 12/15	$ 19,988.27	Per Admin Policy 2-201 and Gov Code sections 910 and 911.2 invoices older than one year require Board approval.	SEE ATTACHED MEMO FROM DEPARTMENT
40401/799390	MENTAL HEALTH	MOUNTAIN VALLEYS HEALTH CENTERS INC	OUTPATIENT MENTAL HEALTH SERVICES 1/16	$ 10,056.81	Per Admin Policy 2-201 and Gov Code sections 910 and 911.2 invoices older than one year require Board approval.	SEE ATTACHED MEMO FROM DEPARTMENT
	TOTAL			**$ 30,045.08**		

Auditor's Certification:
I certify that the foregoing is a true list of claims properly and regularly coming before the Shasta County Board of Supervisors, and that the computations are correct.

Date: 6/19/2017 Signature:

Approval of Claims:
These claims were allowed and the Claims List was approved as correct, by vote of the Board of Supervisors on this date.

Date:

Chairman
Board of Supervisors
County of Shasta
State of California

Health and Human Services Agency
Donnell Ewert, MPH, Director

Business and Support Services Branch
Tracy Tedder, Branch Director

1810 Market Street
Redding, CA 96001-1930
P.O. Box 496005
Redding, CA 96049-6005
Phone: (530) 229-8419
Fax: (530) 225-5555
CA Relay Service: (800) 735-2922

Inter-Office Memorandum

To: Brian Muir, Auditor-Controller
From: Tracy Tedder, HHSA Branch Director
Date: June 14, 2017
Re: Board Claim for Mountain Valleys Health Centers

Shasta County HHSA previously had a contract agreement with Mountain Valley Health Centers to provide outpatient services for Mental Health clients in the Intermountain area of Shasta County. The agreement expired on June 30, 2016. Three invoices were presented for payment totaling $20,931.53. The following three invoices for services were provided to HHSA more than a year past the date that services were provided and now require Board of Supervisors approval for payment:

- December 1, 2015 in the amount of $19,988.27,
- January 1, 2016 in the amount of $10,056.81, and
- February 1, 2016 in the amount of a credit of $(9,113.55).

Pursuant to Welfare & Institution Code section 17000, County Mental Health is statutorily responsible for responding and providing mental health services to individuals.

Vend004114-02 MH010116A

MOUNTAIN VALLEYS HEALTH CENTERS, PO Box 277, Bieber CA, 96009

C-4243
40401-799390
MH0001-MH3100
12/15 SVCS

Shasta County Department of Mental Health
P.O. Box 496048
Redding, CA 96001-4246

Check for final report: ☐ Date of Report: 12/1/2015

Term of Contract: Budget Period 07/15-06/16
Period of Report: Dec 2015

Budget Category (1)	Approved Budget (2)	This Period (3)	Previous Periods (4)	YTD (5)	Remaining Balance (7)
Personnel/Position					
Psychologist/LSCW	$ 100,000.00	$ 11,005.48	$ 46,985.97	$ 57,991.45	$ 42,008.55
Case Manager	$ 27,040.00	$ -	$ -	$ -	$ 27,040.00
LCSW	$ -	$ -	$ -	$ -	$ -
MSW	$ 65,000.00	$ 6,766.737	$ 24,948.67	$ 31,715.40	$ 33,284.60
Fringe Benefits	$ 48,010.00	$ 1,296.87	$ 6,731.41	$ 8,028.28	$ 39,981.72
Total Salary and Benefits	**$ 240,050.00**	**$ 19,069.08**	**$ 78,666.05**	**$ 97,735.13**	**$ 142,314.87**
Operating Expenses					
Office Expenses/Supplies	$ 3,000.00	$ -	$ -	$ -	$ 3,000.00
Equipment	$ -	$ -	$ -	$ -	$ -
Rents/Leases	$ -	$ -	$ -	$ -	$ -
Utilities/Communications	$ 3,000.00	$ 89.84	$ 445.42	$ 535.26	$ 2,464.74
Travel	$ 4,000.00	$ -	$ -	$ -	$ 4,000.00
Software		$ -			
Total Operating Expenses	**$ 10,000.00**	**$ 89.84**	**$ 445.42**	**$ 535.26**	**$ 9,464.74**
Total Expenses	**$ 250,050.00**	**$ 19,158.92**	**$ 79,111.47**	**$ 98,270.39**	**$ 151,779.61**
Administrative Expenses	**$ 37,507.00**	**$ 2,873.84**	**$ 11,866.72**	**$ 14,740.56**	**$ 22,766.44**
Totals	$ 287,557.00	$ 22,032.76	$ 90,978.19	$ 113,010.95	$ 174,546.05
Revenue	$ 173,782.00	$ 2,044.49	$ 86,307.77	$ 88,352.26	$ 85,429.74
Net Contract Costs	**$ 113,775.00**	**$ 19,988.27**	**$ 4,670.42**	**$ 24,658.69**	**$ 89,116.31**
Invoice Total	**$ 19,988.27**				

OK to pay CK 3/6/17

Prepared by: Stephanie House 1/1/2016 Telephone #: 530-294-5241

I certify that this claim is in all respects true, correct, supportable by available documentation, and in compliance with all terms/conditions, laws, and regulations governing its payment.

Stephanie House
Authorized Fiscal Signature Date: 01/01/2016

Program details reviewed by HIPSA. All supporting documentation is on file in Dept. Per HIPAA Regulations all confidential information is blocked. CK

COUNTY OF SHASTA

STATE OF CALIFORNIA AUTHORIZATION FOR RELEASE OF FUNDS (ONE INVOICE PER FORM)

CLAIMANT NAME: Mountain Valleys Health Centers, Inc

PEID: Vend004114 **ADDR TYPE (01,02,03,):** 02

INV #: MH010116A

INV DATE: ~~03/06/17~~ 1/1/16

AMOUNT	COST CNTR	ACCT	PROJ CODE	ACTY CODE	DESCRIPTION (30 CHAR)	VENDOR ACCT # SECONDARY REF	RI 1099 INC RE MH	PJ CHK PU AT PT ID
19,988.27	40401	034800	MH2001	MH3100	December 2015 Invoice			
19,988.27	TOTAL				EXPLANATION (TEXT)			

ADDRESS: (If different from remittance advice or if no invoice)

P.O. Box 277
Bieber, CA
96009

PO/ CONTRACT/ BLANKET PO # C-4243

PARTIAL	FULL
	X

For Value Received, I hereby sell, assign, transfer, and set over to _____ all my right, title and interest in the within claim.

Signed _____

The undersigned, under penalty of perjury, states that the above claim and the items as therein set out are true and correct; that no part thereof has heretofore been paid, and that the amount herein is justly due this claimant, and that the same is presented within one year after the last item thereof has accrued. Furthermore, if I am a county or district employee, I also certify that I have deducted the value of any personal gain I may have received including, but not limited to, cash back earned on a personal credit card, frequent flier miles, and room-stay rewards.

AUDITOR USE ONLY

I hereby certify that the above claim was examined and approved by this office.

By Deputy County Auditor

USER ID

DATE

DISTRICT USE ONLY

APPROVED BY:

BOARD MEMBER	DATE
BOARD MEMBER	DATE
BOARD MEMBER	DATE
BOARD MEMBER	DATE
BOARD MEMBER	DATE

I hereby certify, under penalty of perjury, that I have not violated any of the provisions of Article Four, Chapter One, Division Four, Title One of the Calif. Gov. code. Furthermore, that the articles or services specified in the above claim were necessary and were ordered by me for the purpose indicated above; that the articles or services have been delivered or performed as stated hereon except as otherwise indicated above by me.

CLAIMANT SIGNATURE Stephanie Howe

DATE 03/06/17

AUTHORIZED SIGNATURE Chari Koeller

DATE 3/6/17

Vend004114-02 MH020116A

MOUNTAIN VALLEYS HEALTH CENTERS, PO Box 277, Bieber CA, 96009 C-4243

Shasta County Department of Mental Health
P.O. Box 496048
Redding, CA 96001-4246

40401-79930
MH0001-MH3100
1/16 SVCS

Check for final report: ☐ Date of Report: 1/1/2016

Term of Contract: Budget Period 07/15-06/16
Period of Report: Jan 2016

Budget Category (1)	Approved Budget (2)	This Period (3)	Previous Periods (4)	YTD (5)	Remaining Balance (7)
Personnel/Position					
Psychologist/LSCW	$ 100,000.00	$ 9,052.32	$ 57,991.45	$ 67,043.77	$ 32,956.23
Case Manager	$ 27,040.00	$ -	$ -	$ -	$ 27,040.00
LCSW	$ -	$ -	$ -	$ -	$ -
MSW	$ 65,000.00	$ 5,381.26	$ 31,715.40	$ 37,096.66	$ 27,903.34
Fringe Benefits	$ 48,010.00	$ 1,296.88	$ 8,028.28	$ 9,325.16	$ 38,684.84
Total Salary and Benefits	**$ 240,050.00**	**$ 15,730.46**	**$ 97,735.13**	**$ 113,465.59**	**$ 126,584.41**
Operating Expenses					
Office Expenses/Supplies	$ 3,000.00	$ -	$ -	$ -	$ 3,000.00
Equipment	$ -	$ -	$ -	$ -	$ -
Rents/Leases	$ -	$ -	$ -	$ -	$ -
Utilities/Communications	$ 3,000.00	$ 121.04	$ 535.26	$ 656.30	$ 2,343.70
Travel	$ 4,000.00	$ -	$ -	$ -	$ 4,000.00
Software		$ -			
Total Operating Expenses	**$ 10,000.00**	**$ 121.04**	**$ 535.26**	**$ 656.30**	**$ 9,343.70**
Total Expenses	**$ 250,050.00**	**$ 15,851.50**	**$ 98,270.39**	**$ 114,121.89**	**$ 135,928.11**
Administrative Expenses	**$ 37,507.00**	**$ 2,377.73**	**$ 14,740.56**	**$ 17,118.29**	**$ 20,388.72**
					2
Totals	$ 287,557.00	$ 18,229.23	$ 113,010.95	$ 131,240.18	$ 156,316.83
Revenue	$ 173,782.00	$ 8,172.42	$ 88,352.26	$ 96,524.68	$ 77,257.32
Net Contract Costs	**$ 113,775.00**	**$ 10,056.81**	**$ 24,658.69**	**$ 34,715.50**	**$ 79,059.51**
					0
Invoice Total	**$ 10,056.81**				

OK to pay
CK 3/6/17

Prepared by: Stephanie House 2/1/2016 Telephone #: 530-294-5241

I certify that this claim is in all respects true, correct, supportable by available documentation, and in compliance with all terms/conditions, laws, and regulations governing its payment.

ENTERED ZE
JUN 15 2017
OH634802

Stephanie House
Authorized Fiscal Signature Date: 02/01/2016

Program details reviewed by HHSA. All supporting documentation is on file in Dept. Per HIPAA Regulations all confidential information is blocked. CV

COUNTY OF SHASTA

STATE OF CALIFORNIA AUTHORIZATION FOR RELEASE OF FUNDS (ONE INVOICE PER FORM)

CLAIMANT NAME: Mountain Valleys Health Centers, Inc

PEID: Vend004114 **ADDR TYPE (01,02,03,):** 02

INV #: MH020116A

INV DATE: ~~03/06/17~~ 2/1/16

AMOUNT	COST CNTR	ACCT	PROJ CODE	ACTY CODE	DESCRIPTION (30 CHAR)	VENDOR ACCT # SECONDARY REF	R1 1099 NC RE MH	R2 CHK PO AT PT ID
10,056.81	40401	034800	MH0001	MH3100	January 2016 Invoice			
10,056.81	TOTAL				EXPLANATION (TEXT)			

ADDRESS: (If different from remittance advice or if no invoice)

P. O. Box 277
Bieber, CA
96009

PO/ CONTRACT/ BLANKET PO # C-4243

PARTIAL	FULL
	X

For Value Received, I hereby sell, assign, transfer, and set over to _____ all my right, title and interest in the within claim.

Signed _____

The undersigned, under penalty of perjury, states that the above claim and the items as therein set out are true and correct; that no part thereof has heretofore been paid, and that the amount herein is justly due this claimant, and that the same is presented within one year after the last item thereof has accrued. Furthermore, if I am a county or district employee, I also certify that I have deducted the value of any personal gain I may have received including, but not limited to, cash back earned on a personal credit card, frequent flier miles, and room-stay rewards.

AUDITOR USE ONLY

I hereby certify that the above claim was examined and approved by this office.

By Deputy County Auditor USER ID

DATE

DISTRICT USE ONLY

APPROVED BY:

BOARD MEMBER	DATE
BOARD MEMBER	DATE
BOARD MEMBER	DATE
BOARD MEMBER	DATE
BOARD MEMBER	DATE

I hereby certify, under penalty of perjury, that I have not violated any of the provisions of Article Four, Chapter One, Division Four, Title One of the Calif. Gov. code. Furthermore, that the articles or services specified in the above claim were necessary and were ordered by me for the purpose indicated above; that the articles or services have been delivered or performed as stated hereon except as otherwise indicated above by me.

CLAIMANT SIGNATURE Stephanie Howe

DATE 03/06/17

AUTHORIZED SIGNATURE Chari Koller

DATE 3/6/17