DOUGLAS COUNTY
COLORADO

Memorandum of Understanding

This Memorandum of Understanding ("MOU") sets forth the terms of agreement between the BOARD OF COUNTY COMMISSIONERS OF THE COUNTY OF DOUGLAS, STATE OF COLORADO, (the "County") a political subdivision of the State of Colorado, the DOUGLAS COUNTY MENTAL HEALTH INITIATIVE ("DCMHI"), a collaborative partnership of community-based organizations founded by Douglas County, ALLHEALTH NETWORK, a non-profit behavioral health organization authorized to do business in Colorado; CARING COMMUNITIES OF COLORADO, LLC, a Colorado limited liability company; ADVENT HEALTH, a non-profit health care network authorized to do business in Colorado; COLORADO ACCESS, INC, a non-profit health plan authorized to do business in Colorado; DEVELOPMENTAL PATHWAYS, INC., a non-profit organization authorized to do business in Colorado; DOUGLAS COUNTY DEPARTMENT OF HUMAN SERVICES, a division of Douglas County Government; DOUGLAS COUNTY DEPARTMENT OF COMMUNITY DEVELOPMENT, a division of Douglas County Government; HCA-HEALTHONE d/b/a SKY RIDGE MEDICAL CENTER, a healthcare system and division of HCA Healthcare authorized to do business in Colorado; JULOTA, a Colorado limited liability company; THE ROCK CHURCH, a Colorado non-profit and faith-based organization; ROCKY MOUNTAIN HUMAN SERVICES a Colorado non-profit; SIGNAL BEHAVIORAL HEALTH NETWORK, a Managed Service Organization authorized to do business in Colorado; 18th JUDICIAL DISTRICT PROBATION DEPARTMENT, a department of the 18th JUDICIAL DISTRICT that serves ARAPAHOE, DOUGLAS, ELBERT, and LINCOLN counties; DOUGLAS COUNTY SHERIFF'S OFFICE, an elected office within DOUGLAS COUNTY GOVERNMENT (DCSO); COMMUNITY JUSTICE SERVICES (CJS), a division of Douglas County Government; and the ARC ARAPAHOE, DOUGLAS, and ELBERT COUNTIES, a non-profit advocacy and education organization, collectively referred to as the "Parties" and individually as a "Party."

WHEREAS, the Parties work together in collaboration and acknowledge their commitment to one another to improve patient care, health and quality of life outcomes of citizens, residents and other individuals within Douglas County by increasing access and improving care coordination for behavioral health services (the "Services"), furthering mutual business interests through a formalized Care Compact; and

WHEREAS, The Care Compact ("TCC"), shall serve individuals with complex needs including social determinants of health, mental health, substance use disorder and/or intellectual and developmental disabilities; and

WHEREAS, such Services and collaborative consultation will be provided by the Parties representing healthcare facilities, non-clinical and clinical providers, governmental organizations and faith-based organizations.

NOW THEREFORE, in consideration of the mutual covenants and agreements contained herein, the Parties agree as follows:

A. **The Purpose of this Memorandum.** This MOU is created to document the arrangements and responsibilities between the Parties to assist those citizens, residents and other individuals within Douglas County participating in TCC, a program of the DCMHI.

B. **Party Responsibilities.**

1. All Parties:
   - **a.** All Parties agree that they will work together collaboratively to provide services to the participants of TCC, and that a best faith effort will be made to reach solutions and improve participant care, health, and quality of life outcomes to assist individuals in reaching their desired potential and self-sufficiency.
   - **b.** All Parties agree to ongoing and persistent person-centered and culturally competent engagement, and to the approach that there is no wrong door to initiate services.
   - **c.** All Parties recognize that they have an essential role to play in participant engagement, at referral and throughout the program, and in supporting participant motivation for change. This includes a commitment to identifying individuals who would benefit from TCC's services, competence with describing the program to interested clients, an ability to walk clients through the intake process, and collecting necessary information and releases to refer clients to the program.
   - **d.** All Parties agree that confidentiality of the information provided by the participants in TCC must be protected and that each Party shall protect client information which is designated as sensitive, private or confidential, pursuant to any provision of a federal or state law, rule, or regulation or local ordinance or resolution, specifically the HIPAA privacy law and 42 CFR Part II, further outlined in The Care Compact Business Associate Agreement.
   - **e.** All Parties agree to use consent for release of information form(s) that are acceptable to all Parties and that is/are compliant both with HIPAA and 42 CFR Part II for the protection of the community participant, their Protected Health Information ("PHI") and electronic Protected Health Information ("ePHI"). All Parties agree that when they obtain the consent of the participant or the consent of a legal representative with legal authority to consent to release information, the party obtaining consent will explain to the client of the TCC program and that information will be shared between the parties.
   - **f.** All Parties agree to use and accept a shared referral form to refer participants into TCC and trigger the development of a Care Compact Team and the development of a shared Care Plan designed to develop and/or implement continuity of care for the client. All Parties agree to accept and vet referrals from all Parties in a timely fashion.
   - **g.** All Parties agree to use and accept a shared Care Compact Care Plan to identify and outline each participant's Care Compact Team, manage information collection and sharing, outline Party accountability in the form of action items for immediate stabilization and safety, short- and long-term outcomes, and other information.
   - **h.** All Parties in a Care Compact Team agree to meet or respond within 48 hours, or as quickly as is practicable following an urgent referral, and within 5-7 business days, or as soon as practicable, when receiving a routine referral.

i. All Parties agree to attend Care Compact Team meetings as indicated and relevant based on identified client need(s) and identified risk factors. All Parties agree to attend Care Compact Team meetings at the frequency determined necessary by the Care Compact Team in each individual case and agree to re-assess the frequency of meetings regarding a TCC client on an ongoing basis.

j. All Parties agree to use Julota (or work towards solutions for using Julota within their agency), a commercial, web-based software product that allows for information gathering, sharing, and collaboration on common clients. All Parties will enter information and communications into Julota as it relates to care coordination and relevant Care Compact Team updates including care plans, brief interaction and contact notes with TCC clients (i.e., if a TCC client presents at an emergency department partnering in TCC and this information would be beneficial for TCC partners to know), and program metrics for ongoing data collection and evaluation.

k. All Parties agree to make available an agency decision maker(s) for The Care Compact Leadership Team, and a point(s) of contact with expertise in organizational operations, care and case management for The Care Compact Operations Team. All Parties agree to strive for stability in their appointees to both the Leadership and Operations Teams and make reasonable efforts to designate a proxy when unable to attend a TCC meeting.

l. All Parties agree to cooperate with the Care Compact Administrator and Navigator to facilitate the smooth operation of TCC process.

m. All Parties will participate with data collection as set forth by the DCMHI, for ongoing evaluation and quality improvement of TCC.

n. All Parties agree to the program Scope of Work (Exhibit A).

2. COUNTY.

a. COUNTY ADMINISTRATION. In addition to the responsibilities outlined in section B.1 above, the County will provide, through its Mental Health Initiative Coordinator, Care Compact Administrator, Care Compact Navigator(s), and other staff, administrative support and project management for mutually agreed upon policies and procedures as well as data collection as determined relevant, and evaluation pertaining to TCC. The County will provide access to, and coordinate training with, a web-based, mobile integrated care management software through a contract with Julota, and trainings on TCC program operations to partner staff Access to information available through DCMHI, TCC, and Julota shall be on a "Need to Know" basis and continued access to such information shall be based upon compliance with access to only those members of an entity actively involved and with a legitimate and legal "Need to Know" basis.

b. DOUGLAS COUNTY DEPARTMENT OF HUMAN SERVICES. In addition to the responsibilities outlined in section B.1 above, Douglas County Department of

Human Services agrees to streamline access to eligibility services for TCC clients who qualify and make available a representative from Adult Protection or Child Welfare if a TCC client is at risk of system involvement, or currently has system involvement.

c. DOUGLAS COUNTY DEPARTMENT OF COMMUNITY DEVELOPMENT. In addition to the responsibilities outlined in section B.1 above, Douglas County Department of Community Development agrees to consult on cases where basic needs are unmet, employment is a need, and self-sufficiency programs, such as DC Cares are appropriate. Additionally, in matters where TCC clients are unhoused or facing homelessness, Community Development will make available someone from HEART to participate in Care Teams and consult on cases, as appropriate.

3. ALLHEALTH NETWORK. In addition to the responsibilities outlined in section B.1 , AllHealth Network agrees to provide, as the community mental health center in Douglas County, a continuum of mental health and substance misuse/use disorder treatment services, including therapy, medication management, and case management, at the appropriate level of care for participants in TCC as needed.

4. CARING COMMUNITIES OF COLORADO, LLC (CCC, LLC). In addition to the responsibilities outlined in section B.1 above, Caring Communities of Colorado, LLC, as a part of regular supervision and case consultation, agrees to provide assistance to Community Response Team ("CRT") clinicians and resource specialists in identifying participants who meet criteria for TCC. CCC, LLC also agrees to dedicate on a part-time basis one of its resource specialists to assist The Care Compact Navigator with clients referred by the CRT, and others pending capacity.

5. COLORADO ACCESS, INC. In addition to the responsibilities outlined in section B.1 above, Colorado Access agrees to make available and provide, as the Regional Accountable Entity for Douglas County, a representative from the Behavioral Health Division at Care Compact Team meetings for TCC clients with Medicaid, and to provide care coordination, case management, system navigation and other services associated with the responsibilities of the Regional Accountable Entity.

6. DEVELOPMENTAL PATHWAYS, INC. In addition to the responsibilities outlined in section B.1 above, Developmental Pathways agrees, as Douglas County's designated Case Management Agency (CMA), to provide intake and enrollment support to referred TCC clients, as well as provide ongoing services and case management support once eligibility is determined for specific programs/waivers. This will include participating in Care Teams for clients who are referred for HCBS Services, offering additional support and streamlined connections as appropriate.

7. JULOTA. Julota is a web-based software product that allows for cross-system information gathering, sharing, and collaboration on shared clients. In addition to the

responsibilities outlined in section B.1 above, Julota agrees to provide training to TCC partners as needed, and coordinate with the County to manage trainings and onboarding. Protected Health Information ("PHI") contained in Julota may be input by certain Parties of TCC who are covered entities, and other information relevant to a TCC participant's Care Plan may be input by certain Parties of TCC who are community-based organizations and non-covered entities. All Parties with access to PHI in Julota shall execute legal and appropriate Business Associate Agreements in compliance with HIPAA, 42 CFR Part II and other laws related to confidentiality and privilege as necessary and appropriate. Parties agree to develop communication strategies to allow the sharing of information necessary to protect the safety of TCC participants and TCC partners in accordance with HIPAA, 42 CFR Part II, or other applicable federal, state or local law or regulation related to PHI.

8. THE ROCK CHURCH. In addition to the responsibilities outlined in section B.1 above as relevant, The Rock Church agrees to provide, through their faith-based organization and/or through the network of faith-based organizations in Douglas County, those safety net services to address social determinant of health factors for participants in TCC as needed. The Rock Church also agrees to assist with access to Care Portal to fulfill identified needs of TCC clients and, as needed, work with the County, Care Portal, and Julota on system integration.

9. ROCKY MOUNTAIN HUMAN SERVICES. In addition to the responsibilities outlined in section B.1 above, Rocky Mountain Human Services agrees to provide case consultation as a part of a Care Compact Team as needed, intake and case management for TCC clients and/or to receive referrals for clients who may be moving out of Douglas County to RMHS' catchment area as a Case Management Agency.

10. SIGNAL BEHAVIORAL HEALTH NETWORK. In addition to the responsibilities outlined in section B.1 above as relevant, Signal Behavioral Health Network agrees to provide consultation on TCC cases where utilization of the crisis system and/or substance use disorder ("SUD") are factors and there is a need from the participant's Care Compact Team to explore options for crisis stabilization or ongoing SUD treatment. Signal Behavioral Health Network is not acting as a provider and therefore cannot redisclose substance use disorder data and information on behalf of other Parties or subcontractors. TCC must obtain this information directly from a provider.
11. 18th JUDICIAL DISTRICT PROBATION. In addition to the responsibilities outlined in section B.1 above, 18th Judicial Probation agrees to collaborate with a client's Care Team, when a client gives permission, to share conditions of probation, updates on a client's case/legal status, and information related to a client's needs or barriers to compliance. Probation may act as, primarily, a referring partner, but may collaborate with the Care Team to help a client meet their goals and reduce/prevent recidivism.
12. DOUGLAS COUNTY SHERIFF'S OFFICE. In addition to the responsibilities outlined in section B.1 above, Douglas County Sheriff's Office agrees to provide case consultation

for existing TCC clients housed in the Detention Division to offer a smoother transition from jail to the community via the Reintegration programs and supporting staff.

13. COMMUNITY JUSTICE SERVICES. In addition to the responsibilities outlined in section B.1 above, CJS agrees to collaborate with a client's Care Team, when a client gives permission, to share conditions of bond, updates on a client's case/legal status, and share information related to a client's needs or barriers to care and compliance. CJS may act as, primarily, a referring partner, but may collaborate with the Care Team to help a client meet their goals and reduce/prevent recidivism.
14. THE ARC ARAPAHOE, DOUGLAS, AND ELBERT COUNTIES. In addition to the responsibilities outlined in section B.1 above, the Arc agrees to receive referrals, collaborate with a client's Care Compact Team, and provide advocacy support to eligible TCC clients. The Arc may also offer consultation and recommendations for appropriate educational opportunities that may benefit individuals with IDD and their families.

C. Scope of Services. All Parties agree to the services and guiding principles outlined in section B.1, additional requirements outlined in Section B.2 - B.11 as relevant and services described in Exhibit A, attached hereto and incorporated herein, which shall be performed by TCC partners. The County may, from time to time, request that changes be made to the scope of services to be performed hereunder. Such potential changes shall be in writing and shall become part of this Agreement if mutually agreed upon by the County and the Parties upon execution of the change(s). All Parties agree to diligently and professionally perform all services described herein.

D. Term

This MOU shall take effect effective _____, 2023 upon full execution by all Parties. The Parties agree that this MOU shall continue in perpetuity with the agreement of all Parties, unless a Party can no longer meet the standards of this Agreement or can no longer play a role in TCC. Parties may opt-out of this Agreement by providing a 60-day written notice to Douglas County. Written notices shall be mailed to:

Attn: Leandra Montoya

4400 Castleton Court

Castle Rock, CO 80109

E. No Waiver of Governmental Immunity Act. The Parties hereto understand and agree that the County, its commissioners, officials, officers, directors, agents and employees are relying on and do not waive or intend to waive by any provisions of the Agreement, the monetary limitation or any other rights, immunities and protections provided by the Colorado Governmental Immunity Act 24-10-101 to 120, C.R.S. as amended or otherwise available to the County.

F. It is understood and agreed by and among the Parties that each department, entity or agency's employees shall remain employees of that department, entity or agency at all times, and for all

purposes, notwithstanding any employee's department, entity or agency's work with the DCMHI Care Compact, and it is not intended, nor shall it be construed, that any department, entity or agency's employees, or agents of such department, entity or agency is an officer, employee, loaned employee or agent of the other department, entity or agency for purposes of Unemployment Compensation, Workers' Compensation, governmental immunities and protection provided by the Colorado Governmental Immunity Act, C.R.S § 24-10-101 *et seq*., or for any other purpose whatsoever.

G. For the avoidance of doubt, the relationship of the Parties under this Agreement is not one of legal partnership, joint venture or agency. This Agreement is not a fiscal obligation for commitment for funds. The Parties intend this document to be a statement of cooperative intent, rather than legally binding.

H. Publicity/Communications – all parties agree to acknowledge Douglas County and the Douglas County Mental Health Initiative as a contributor and administrative support organization of The Care Compact (TCC) pursuant to this MOU in all publications, news releases, and other publicity issued by any of the Parties and allow the County to do the same. The Parties agree to work together on joint communication strategies, through established channels (i.e. organizational public affairs or public relations staff), related to activities, services, programs and evaluations of TCC.

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DOUGLAS COUNTY
COLORADO

EXHIBIT A

SCOPE OF WORK

This Scope of Work ("SOW") outlines the criteria and activities of The Care Compact ("TCC") program. TCC program will explore the impact of a collaborative approach to crisis stabilization, care coordination, and continuity of care planning across partners in physical and mental health care, substance use disorder treatment, intellectual and developmental disability services, human services, and safety net services. Parties across these sectors will work together in a formalized Care Compact to serve some of Douglas County's most vulnerable citizens, adults with complex mental health, substance use and/or intellectual and developmental disability (IDD) needs, as well as unmet basic needs or social determinants of health (SDoH). This fully launched program will continue to evaluate process and procedures to ensure the program aligns with the Behavioral Health Administration's (BHA) regional case management model and recommendations for care coordination and to attend to changes needed to promote care that is person-centered, culturally appropriate, and attentive to other systemic issues and barriers.

1. **Guiding principles.** All Parties recognize the following guiding principles as core to the TCC model and agree to strive for the following standards:
    a. Information sharing is essential for the purposes of continuity of care, care coordination, and effective action planning. Parties agree to use Julota and to continually work toward solutions that allow for information sharing between agencies while protecting the privacy of TCC clients.
    b. Parties agree to work towards a system that is networked and integrated, leverages the knowledge and expertise of multiple stakeholder agencies, and is person-centered and culturally responsive.
    c. Parties agree to the approach that there is no wrong door to initiate services. Parties should rely on each other to solve tough problems and effectively coordinate care for TCC clients.
    d. Parties will be responsive to TCC communications. Parties will make themselves available to respond to referrals at all levels of urgency and will consistently attend programmatic (i.e. Operations and Leadership) Care Compact meetings.
    e. Data collection and evaluation is an essential part of program development, implementation and continuous quality improvement. Parties agree to participate in data collection relevant to their organization's capacity and as permitted through HIPAA, CFR 42 Part 2, and/or CJIS compliance standards. If a Party requires an additional release of information to collect essential TCC data from clients for the purposes of program evaluation and continuous quality improvement, that Party will collect that release as part of the client's intake and will upload the signed release to the client's Julota profile. Parties agree to ongoing and persistent person-centered engagement, while keeping in mind clients with serious mental illnesses, different abilities, varying safety needs, and capacities may require creative approaches to engagement and/or accommodations to improve access to care.

2. Criteria. TCC will provide care coordination, cross sector collaboration, and additional community supports as indicated to adults (18+) with a mental health need, substance use disorder need, intellectual and/or developmental disability who would also benefit from cross-system coordination. In addition to the core needs and diagnoses identified as part of the core criteria above, individuals referred to TCC may have the following co-occurring conditions, needs, or indicators of system penetration:

i. A co-occurring physical health condition
ii. A co-occurring traumatic brain injury (TBI)
iii. Engagement with the criminal justice system
iv. Engagement with child welfare or adult protection
v. Individual has had emergency department utilization in the last 60 days for specific mental health, substance use or behavioral challenges
vi. Individual has a diagnosis of mental health or substance use AND has been admitted for an inpatient psychiatric or SUD episode in the last 60 days
vii. Individual has a diagnosis of mental health or substance use AND has been admitted for an inpatient medical condition in the last 60 days
viii. Individual has had a crisis contact either through Douglas County CRT or Crisis Services in the last 60 days
ix. Individual has had a contact with law enforcement outside of Douglas County CRT in the last 60 days
x. Individual will be discharged from an inpatient psychiatric/SUD facility in the next 30 days
xi. Individual will be released from a criminal justice setting in the next 30 days
xii. Individual is at high risk for child welfare engagement
xiii. Individual has high social determinants of health (SDOH) needs such as transient housing, food insecurity, and others that are relevant to clinical presentation/diagnosis

Parties agree to reassess criteria throughout the program for a client to be eligible for Care Compact services.

3. Release of Information. TCC program will observe practices regarding use of consent for sharing of information forms acceptable to all Parties. Parties agree to work in partnership to continuously discuss, negotiate and develop requirements in a shared consent to release information form. All Parties recognize that while a shared consent to release information is under development TCC may utilize multiple releases to ensure necessary and proper sharing of information for the purposes of continuity of care planning.

4. Julota. Throughout the program and as TCC clearly defines the process and workflow, Julota, a mobile, integrated community case management software, will be engaged to customize the software platform for the purposes of managing TCC activities and tracking data for program evaluation. At a minimum, all Parties will utilize access to Julota to keep track of ROIs, Interactions entered by other team members, and any updates to services, the Care Plan, and associated action items to prevent the duplication of services and streamline collaboration efforts. Preferably, all Parties will work internally to establish the use of Julota by one or more staff members to share minimum necessary or "need to know" information in Julota via Interactions to support efficient care coordination efforts and reduce reliance on email updates. This will also improve security of sensitive client information and limit the need for frequent

check-ins with the Care Team. Throughout the program, Parties will continue conversations about the types of information that will be shared via Julota for effective care coordination and any necessary Business Associate Agreements for the purposes of information sharing and collaboration on the platform.

5. Referral. Any Party, DCMHI Partner, or family/community member can refer to TCC. Parties will use the shared referral form created by the Care Compact Operations Team. Crisis and urgent referrals will be processed, and the Care Compact Team assembled within 48 hours, or as quickly as is practicable following an urgent referral, and within 5-7 business days, or as soon as practicable, when receiving a routine referral. Parties agree to continue to review and refine the referral form and process throughout the program so that it meets the needs of all Parties and target populations.

6. Care Compact Team and Care Plan. Following referral, and if a participant meets criteria, a Care Compact Team will form based on the needs identified in the referral. Each participant will have a Care Compact Team, and each team will have a lead assigned, with support from The Care Compact Navigator and other service providers as indicated in the referral. Emphasis will be placed on addressing safety needs, determining goals, clarifying roles, assigning tasks or responsibilities, and preventing the duplication of services. The Care Compact Team will communicate electronically to address immediate needs and meet within 48 hours or as soon as practicable for crisis and urgent referrals. For routine and standard referrals, team members will establish expectations for addressing immediate needs via electronic communications and a timeline for the initial team meeting (preferably within 5-7 business days or as soon as practicable). All Parties agree to continue to evaluate and develop the staffing process and procedure throughout the program so that it meets the needs of all Parties.

7. Metrics, data collection and evaluation. Defining metrics and collecting data are key steps in evaluating TCC. Parties will define process, outcome, individual and aggregate metrics (metrics of interest below) and Parties agree to develop a strategy for data collection (i.e., is the data available and accessible; who collects the data and when). Parties are interested in, and will explore, developing a cost avoidance formula for TCC.

Individual Metrics	Aggregate Metrics
Reduction of utilization of specific acute care services (e.g., emergency department) Increased utilization of outpatient care and engagement with care team providers.	Aggregate % decrease in: - Emergency Department Utilization - Inpatient hospitalization and readmission - Jail/criminal justice engagement for those with mental health/SUD - Crisis contacts - APS Reports/Referrals Aggregate % increase in: - Appointments (engagement) with new referral sources - Appointments kept with providers
Diversion or risk reduction for engagement in other systems (Child Welfare, Criminal Justice, Adult Protection)	Qualitative description of reduction in risk for other system engagement across program
Stability and improvement in quality of life measures	Aggregate % increase in quality of life ratings
Number of referrals and connections made to additional services (particularly SDoH but also other prevention care providers)	Aggregate number of referrals made

	Aggregate number of services provided, preferably, categorized by goal/need areas
Reduction in SDoH needs as indicated by validated tool or assessment	Aggregate reduction in SDoH needs
Number of coordination team meetings with care compact team (process measure)	Aggregate number of care compact team meetings (process measure)

8. TCC Leadership Team. TCC Leadership Team shall have representation from each of the TCC program Party agencies. Leaders should be decision makers in their agency with the ability to provide TCC with strategic direction, approve agreements, make funding decisions and approve data sharing for program evaluation. The TCC Leadership Team will meet as needed, approve programmatic changes throughout the program, and address any challenges or barriers that arise.

9. TCC Operations Team. TCC Operations Team ("Team"), with support from The Care Compact Navigator, is tasked with program design, organizational education and uptake (program champions), implementation, and evaluation. The Team shall have representation from each of TCC program Party agencies. Members of the Team should understand the operations of their respective agencies and ideally work closely with a team of case managers or care coordinators. The Team will be involved in the ongoing evolution and development of the program including Care Compact Team meeting process, internal and external communication plans, building network knowledge, and addressing programmatic pain points. The Team will also provide feedback throughout the implementation of the collaborative software, Julota, ongoing development of the Universal Release of Information ("U-ROI"), this Agreement, and execution of Business Associates Agreements as needed. Team members will ensure that any request made of their organization to internally review TCC agreements or documents will be done in a timely fashion and by the appropriate leadership or legal representative(s). The Team will adjust TCC documents and processes as needed and agrees to participate in this group as a means to resolve outstanding system issues. The Team will meet regularly to assess program capacity, provide organizational updates, communicate on system updates and challenges, and assess the need for TCC changes/improvements.

[Signature Page to Follow]

IN WITNESS WHEREOF, the Parties have executed this Agreement on the day and year first above written.

BOARD OF COUNTY COMMISSIONERS
OF THE COUNTY OF DOUGLAS, COLORADO

For Douglas County:

By: DocuSigned by: Doug DeBord
DOUGLAS J. DEBORD
County Manager
Date: 12/18/2023

APPROVED AS TO LEGAL FORM:
By: DocuSigned by: Amy Edwards
AMY EDWARDS
Senior Assistant County Attorney
Date: 12/18/2023

DOUGLAS COUNTY MENTAL HEALTH INITIATIVE
By: DocuSigned by: Barbara Drake
BARBARA DRAKE
Deputy County Manager
Date: 12/18/2023

Address for Notices to:
Douglas County Government, Attn: Barbara Drake
100 Third Street
Castle Rock, CO 80104

For AllHealth Network:
By: DocuSigned by: William Henricks
DR. WILLIAM HENRICKS
President, Chief Executive Officer
Date: 12/18/2023

DOUGLAS COUNTY
COLORADO

For Caring Communities of Colorado, LLC:

By: James R. Baroffio
DR. JIM BAROFFIO
Director, Clinical Psychologist
Date: 3/18/2024

For Advent Health:

By: Heidi Bode
Heidi Bode Manager Crisis Assessment
Date: 1/3/2024

For Colorado Access:

By: Dana G Pepper
Dana G Pepper VP, Provider Engagement
Date: 6/17/2024

For Developmental Pathways, Inc.:

By: Matt Van Auken
MATT VAN AUKEN
Chief Executive Officer, Executive Director
Date: 12/21/2023

For Douglas County Department of Human Services:

By: Dan Makelky
DANIEL MAKELKY
Director
Date: 12/18/2023

For HCA-HealthONE d/b/a Sky Ridge Medical Center:

By: _____

Date: _____

DOUGLAS COUNTY
COLORADO

For The Rock Church:

By: DocuSigned by: Mike Pollhemus
MIKE POLHEMUS
Pastor
Date: 12/28/2023

For Rocky Mountain Human Services:

By: _____
NANCY STOKES
Chief Financial Officer
Date: _____

For Signal Behavioral Health Network:

By: DocuSigned by: _____
DANIEL DARTING
Chief Executive Officer
Date: 6/7/2024

For 18th Judicial District Probation:

By: DocuSigned by: _____
DOUGLAS GRAY
Chief Probation Officer
Date: 12/21/2023

For Douglas County Sheriff's Office:

By: DocuSigned by: Bureau Chief Kevin Duffy
Bureau Chief Kevin Duffy
Bureau Chief
Date: 12/21/2023

For The Arc Arapahoe, Douglas, and Elbert Counties:

By: DocuSigned by: Luke Wheeland
DR. GENENE DURAN
Executive Director
Date: 3/19/2024

DOUGLAS COUNTY
COLORADO

For Community Justice Services:
By: DocuSigned by: Scott Matson
SCOTT MATSON
Director of Community Justice Services
Date: 12/21/2023

For Julota:
By:

Date:

For Douglas County Department of Community Development:
By: DocuSigned by: Terence Quinn
TERENCE T. QUINN
Director of Community Development
Date: 12/18/2023