

2026 SCALING DYADIC CARE GRANT PROGRAM REQUEST FOR APPLICATION

Applicant Question Preview

PURPOSE OF DOCUMENT

Applicant Question Preview Overview

This document is provided to assist applicants in reviewing and preparing thoughtful responses prior to submitting the official Qualtrics application. By utilizing this preview, applicants can ensure their answers are comprehensive and aligned with DHCS expectations for Request for Applications (RFAs). Please note that all final responses must be entered directly into the Qualtrics platform.

How to Use the Applicant Question Preview

The Applicant Question Preview is designed to support applicants in preparing responses for the official Qualtrics application. To use this resource effectively:

- » Review Each Question Carefully: Familiarize yourself with the prompts to ensure your responses address all required elements.
- » Draft and Refine Your Answers: Use the preview to organize and strengthen your responses, ensuring clarity and alignment with DHCS priorities for RFAs.
- » Collaborate as Needed: Engage your team or consult relevant resources to enhance the quality of your application.
- » Transfer Final Responses to Qualtrics: Once your answers are complete and reviewed, enter them directly into the Qualtrics application. The Applicant Question Preview is for preparation only and does not replace the official submission process.

SCALING DYADIC CARE GRANT PROGRAM

APPLICATION OVERVIEW

The Scaling Dyadic Care Grant Program is a statewide initiative designed to accelerate the implementation of the Medi-Cal dyadic services benefit across California (SPA 23-0010 and APL 22-029). Through two years of grant funding and intensive technical assistance, the grant program is structured to support participating service locations in developing the clinical, operational, and data infrastructure required to effectively deliver, document, bill for, and sustain dyadic services. This includes strengthening care team integration; establishing standardized workflows; enhancing electronic health records (EHRs) and reporting capabilities; and aligning dyadic services with Medi-Cal reimbursement pathways.

The University of California, San Francisco Center for Advancing Dyadic Care in Pediatrics (UCSF CADP) serves as the Technical Assistance Vendor (TA Vendor), in partnership with the Department of Healthcare Services (DHCS) and a Third-Party Administrator (TPA), the California Institute for Behavioral Health Solutions (CIBHS) to oversee implementation, provide structured coaching and consultation, and guide statewide adoption of dyadic care services. This coordinated support model ensures that grantees receive consistent, high-quality guidance rooted in national best practices for integrated pediatric behavioral health and Medi-Cal benefit implementation.

Competitive applications should demonstrate organizational readiness, strong leadership commitment, a clear implementation strategy, a focus on serving high-need Medi-Cal populations, and the capacity to participate fully in the grant program's technical assistance, reporting, and continuous quality improvement activities.

Application components include completion of the applicant survey and uploads of all required documents in the Qualtrics platform.

Application Tool Checklist Items

A full and complete application consists of the following items:

- » Application Survey
- » Leadership Letter of Support
- » Proposed budget for use of grant funds
- » Resumes of program lead and other key staff

- » Organizational Chart
- » Audited Financial Statement Federally Approved Indirect Rate Cost Letter, if applicable
- » W-9 Form Certificate of Insurance

All documents and application components must be completed and uploaded through [Qualtrics - Dyadic Service Grant Application](#). It is recommended that applicants gather information on the application components outlined in the RFA in section 3.2 Application Components before beginning the survey.

Finishing your application later

The application survey is best completed in one sitting. If you need to stop and return to the application at a later time, your progress is saved automatically as you complete each section of the application. If you need to stop, simply close your browser and return later using the same application link, browser, and device to continue where you left off.

Important: If you switch devices or browsers, clear your browser history or cookies, or use private/incognito mode, your saved progress will not be available.

Single-Service Location Application Questions

1. Is the applicant applying as a single-service location or in combination with another service location?

Definition of Service Location:

For purposes of this RFA, a provider service location is a distinct physical clinical site where pediatric or family-serving primary care services are delivered, and Medi-Cal Dyadic Services may be implemented. A provider service location typically: Is a distinct physical location where patient care is provided; Operates as an individual care delivery site; Has its own Medi-Cal enrollment and/or National Provider Identifier (NPI), as applicable; and is operated by an eligible applicant organization).

- Applying as a single-service location application on behalf of one eligible provider service location
- Applying as a multi-service location application on behalf of two eligible provider service locations operating under the same legal entity or through a formal partnership. (Note: Each participating provider service

location must independently meet the eligibility requirements described in Section 2.2. For multi-service location applications: Each participating organization must execute the grant agreement, when applicable. One organization must serve as the Grantee of Record and be responsible for: Receiving and administering grant funds; coordinating implementation across participating provider service locations; and ensuring compliance with all grant requirements)

2. Please review the RFA and confirm the following:

- By checking this box, the applicant confirms that the service location meets the Eligible Service Setting criteria described in Section 2.1 Eligible Applicant Criteria
- By checking this box, the applicant confirms that it has read and agrees to the requirements in section 2.4 TA Engagement and Participation Requirements
- By checking this box, the applicant confirms having read and agreeing to the requirements in Section 2.5 Data Reporting and Grant Monitoring Requirements

3. Please indicate the funding Tier to which the applicant is applying:

- Tier 1: Large provider service location serving greater than or equal to 1,000 Medi-Cal children aged 0 to 5 years and with an expected scope of a full-time staffing model dedicated to dyadic services, including 1.0 FTE or 100% of a full-time staff member dedicated to the target population in the provision of dyadic care (ages 0-5)
- Tier 2: Small to Medium Provider Service Location serving greater than or equal to 500 Medi-Cal children aged 0 to 5 years and with an expected scope of a part-time or phased staffing model, including 0.50 FTE or 50% of a full-time staff member dedicated to the target population in provision of dyadic care (ages 0-5)

4. Who is the point of contact and their contact information for this grant application?

- First name
- Last Name
- Title/role in organization
- Email
- Phone

5. What is the name and contact information for the primary service location applying for the grant? (The primary service location serves as the lead applicant and is legally and fiscally accountable for all grant requirements, reporting, and compliance activities).

- Service Location Name
- Address
- Address 2
- City
- State
- Zip code

6. What is the Medi-Cal designation of the service location applying for the grant?

- Federally Qualified Health Center (FQHC)
- Rural Health Clinic (RHC)
- Indian Health Care Providers (IHCPs)
- Hospital-affiliated health system, specify:
- Community-based organization that operates Medi-Cal enrolled primary care clinics
- Other, specify

7. In order to be considered for the grant opportunity, a Medi-Cal Non-Specialty Mental Health Services (NSMHS) contract must be in place with at least one managed care provider (MCP) at the start of the grant period. What is the current contract status for Medi-Cal NSMHS for the service location applying?

- Fully contracted or in the process of contracting for Medi-Cal NSMHS with at least one MCP
- Not currently contracted or in the process of contracting for Medi-Cal NSMHS with any MCP

8. Which Managed Care Plan providers are contracted or in the process of being contracted for Medi-Cal NSMHS? (select all that apply and their corresponding Medi-Cal NSMHS contract status).

Category	Contract in place for Medi-Cal NSMHS	In the process of contracting for Medi-Cal NSMHS
Anthem Blue Cross Partnership Plan		
Blue Shield of California Promise Health Plan		
Health Net Community Solutions		
Molina Healthcare of California		
Kaiser Permanente (Medi-Cal)		
Partnership HealthPlan of California		
Local/county plan, specify:		
Other, specify:		

PATIENT POPULATION

9. What is the primary county in which the majority of the service location's patients reside?

- ☐ Alameda County
- ☐ Alpine County
- ☐ Amador County
- ☐ Butte County
- ☐ Calaveras County
- ☐ Colusa County
- ☐ Contra Costa County
- ☐ Del Norte County
- ☐ El Dorado County
- ☐ Fresno County
- ☐ Glenn County
- ☐ Humboldt County
- ☐ Imperial County
- ☐ Inyo County
- ☐ Kern County
- ☐ Kings County
- ☐ Lake County
- ☐ Lassen County
- ☐ Los Angeles County
- ☐ Madera County
- ☐ Marin County
- ☐ Mariposa County
- ☐ Mendocino County
- ☐ Merced County
- ☐ Modoc County

- Mono County
- Monterey County
- Napa County
- Nevada County
- Orange County
- Placer County
- Plumas County
- Riverside County
- Sacramento County
- San Benito County
- San Bernardino County
- San Diego County
- San Francisco County
- San Joaquin County
- San Luis Obispo County
- San Mateo County
- Santa Barbara County
- Santa Clara County
- Santa Cruz County
- Shasta County
- Sierra County
- Siskiyou County
- Solano County
- Sonoma County
- Stanislaus County
- Sutter County
- Tehama County

- Trinity County
- Tulare County
- Tuolumne County
- Ventura County
- Yolo County
- Yuba County

10. Annual well-child visit count: What is the approximate total annual well-child and adolescent well-care visit count for the most recent calendar year for the following age groups?

- Annual well-child visits among 0 to 5 year olds:
- Annual well-child visits among 6 to 20 year olds:
- Total:

11. Total patient count: What is the total number of patients served by the service location (count all patients regardless of insurance status) by the following age groups?

- Patients aged 0 to 5 years:
- Patients aged 6 to 20 years:
- Patients aged 21 years or more:

12. Total: Count of patients enrolled in Medi-Cal: What is the total number of patients served who are enrolled in Medi-Cal by the following age groups?

Medi-Cal enrolled patients aged 0 to 5 years:

Medi-Cal enrolled patients aged 6 to 20 years:

Medi-Cal enrolled patients aged 21 years or more:

Total:

13. For Medi-Cal enrolled pediatric patients (patients aged 0 to 20 years), what is the percent distribution by race for the following categories? Percent distribution must total to 100.

Category	% American Indian or Alaska Native	% Asian	% Black or African American	% Native Hawaiian or other Pacific Islander	% White	% Two or more races	% Other/declined/unknown
Medi-Cal enrolled pediatric patients (patients aged 0 to 20 years)							

14. For Medi-Cal enrolled pediatric patients (patients aged 0 to 20 years), what is the percent distribution by ethnicity? The percent distributions must total to 100.

Category	% Hispanic or Latino	% Not Hispanic or Latino	% Declined/unknown/not reported
Medi-Cal enrolled pediatric patients (patients aged 0 to 20 years)			

15. What percent of the Medi-Cal enrolled pediatric population is best served in a language other than English?

- ☐ Less than 5%
- ☐ Greater than or equal to 5% and less than or equal to 25%
- ☐ Greater than 25% and less than or equal to 50%
- ☐ Greater than 50% and less than or equal to 75%
- ☐ Greater than 75%

16. Which best describes how the service location supports language needs?

- No formal approach to supporting language needs
- Use primarily ad hoc or informal solutions, such as informal interpretation by staff or family members
- Use some formal supports, such as interpreters or translated materials for certain services or populations
- Use standardized language access services, such as professional interpreters and translated materials across most services for common patient languages
- Use comprehensive, proactive language access strategies, such as staffing for language needs, standardized translation services, data tracking, and continuous improvement to support language access

17. Which of the following best describes the service location's approach to community engagement for provider services? Select the option that best reflects current practice, not future goals.

- Community input is not routinely gathered to inform services or programs
- Community members provide feedback on existing services, programs, or materials, but do not participate in decision-making
- Community members are consulted at key stages of planning or implementation, and their input may inform decisions
- Community members are engaged on an ongoing basis in program planning, implementation, or evaluation through defined advisory or partnership roles
- Community members share decision-making authority and participate in governance or leadership structures related to services or programs

18. Which structure(s) are currently used to support community engagement? (Select all that apply)

- Surveys or feedback tools
- Periodic listening sessions, focus groups, or interviews
- Community advisory board
- Paid roles (permanent or temporary for a defined role or task)

- Other (please specify):

STAFFING AND SERVICE LOCATION OFFERINGS

The following set of questions collects information on staffing and service location offerings.

19. What is the total combined number of non-duplicated medical providers currently providing primary care services for the service location (on staff or contracted). Include MDs, NPs, DOs, PAs who conduct primary care visits:

20. What is the total workload in full-time equivalent (FTE) among the medical providers allocated for primary care services for the following age groups (For FTE conversion: 1 staff with 100% of their time dedicated to services to a particular age group would equal 1.0 FTE, whereas 1 staff with 50% of their time dedicated to services to a particular age group would equal 0.50 FTE).

- Patients aged 0 to 5 years:
- Patients aged 6 to 20 years:
- Patients aged 21 years or more:
- Total:

21. Are there currently behavioral health providers who are eligible to bill for dyadic services on staff or contracted to provide behavioral health services? If yes, provide the total number of behavioral health providers who are eligible to bill for dyadic services. Note: Behavioral health providers do not need to be currently providing dyadic services to count. Include any behavioral health provider whose provider type is eligible to bill for dyadic services, regardless of whether they currently provide them.

Provider types eligible to bill for dyadic services include:

- Physicians (MD/DO)
- Licensed Clinical Social Workers (LCSWs)
- Licensed Professional Clinical Counselors (LPCCs)
- Licensed Marriage and Family Therapists (LMFTs)

- Psychiatric Physician Assistants (PAs)
 - Psychiatric Nurse Practitioners (NPs)
 - Licensed Psychologists
 - Associate Marriage and Family Therapists (AMFTs)
 - Associate Professional Clinical Counselors (APCCs)
 - Associate Clinical Social Workers (ASWs)
 - Psychological Associates
- » Yes , total number of behavioral health providers eligible to bill for dyadic services who are on staff or contracted:
- » No

22. For each age group below, indicate the availability of behavioral health provider(s) who are eligible to bill for dyadic services and are on staff or contracted to provide behavioral health services to patients in that age group. Note: Behavioral health providers do not need to be currently providing dyadic services.

If yes, enter the total provider full-time equivalent (FTE) allocated to serving patients in that age group. Include only FTE from providers who are eligible to bill for dyadic services.

FTE examples:

- » One provider dedicating 100% of their time to behavioral health services for an age group = 1.0 FTE
- » One provider dedicating 50% of their time= 0.5 FTE total
- » Two providers each dedicating 25% of their time= 0.5 FTE total

Category	Any behavioral health provider time allocated to this age group?		Total FTE for Behavioral Health Services
	Yes	No	
Category Responses			FTE
Patients aged 0 to 5 years			
Patients aged 6 to 20			
Patients aged 21 years or more			

23. Does the service location have any formal partnerships with graduate training programs, academic institutions, or other behavioral health workforce training programs?

- ☐ Yes, specify program:
- ☐ No

24. Does the service location provide training and supervision for trainees or associate-level clinicians?

- ☐ Yes
- ☐ No

25. What trainee or license-eligible roles are currently supported or supervised at the service location? (Check all that apply).

- ☐ Graduate student (marriage and family therapist trainee or social work trainee still enrolled in school)
- ☐ Associate Marriage and Family Therapist
- ☐ Associate Social Worker
- ☐ Psychology postdoctoral intern
- ☐ Postdoctoral fellow
- ☐ Other, please specify:

26. What is the total non-duplicated count of trainees supported at the service location in a year, on average?

27. What is the total workload in full-time equivalent (FTE) among behavioral health trainees for the following age groups?

(For FTE conversion: 1 staff with 100% of their time dedicated to services to a particular age group would equal 1.0 FTE, whereas 1 staff with 50% of their time dedicated to services to a particular age group would equal 0.50 FTE).

- Patients aged 0 to 5 years:
- Patients aged 6 to 20 years:
- Patients aged 21 years or more:
- Total:

28. What is the total non-duplicated count of supervisors for behavioral health trainees?

29. What is the total workload in full-time equivalent (FTE) for supervisors dedicated to supervision of behavioral health trainees for the following age groups.

For FTE conversion: 1 staff with 100% of their time dedicated to services to a particular age group would equal 1.0 FTE, whereas 1 staff with 50% of their time dedicated to services to a particular age group would equal 0.50 FTE).

- Patients aged 0 to 5 years:
- Patients aged 6 to 20 years:
- Patients aged 21 years or more:
- Total:

DYADIC SERVICE IMPLEMENTATION SUPPORTS

The following set of questions collects information on dyadic service provider and implementation support roles for dyadic services.

30. Based on the definitions below, what best describes the service location's staffing readiness to provide dyadic services using behavioral health providers who are eligible to bill for those services? For a full list of provider types eligible to bill for dyadic services, see the DHCS Dyadic Service Manual.

- » **Fully in place**= Additional hiring or contracting of billing-eligible staff is not needed since existing billing-eligible staff is sufficient to support dyadic service implementation or expansion for the target age group or needs can be met through re-allocation of existing billing-eligible behavioral health staff
- » **Mostly in place** = Some additional hiring or minor adjustments in staff allocation may be needed to meet expected demand for dyadic services, however existing billing-eligible staff is largely sufficient to support dyadic service implementation or expansion for the target age group
- » **Partially in place** = Some billing-eligible staff exist to provide dyadic services, but additional hiring or contracting of billing-eligible providers will be needed to meet expected demand.
- » **Need to fully hire** = Will need to fully hire or contract billing-eligible providers to provide dyadic services since billing-eligible staff are not in place to provide dyadic services and/or existing billing-eligible staff cannot be reallocated to support these services.

Category	Need to fully hire	Partially in place	Mostly in Place	Fully in Place
Patients aged 0 to 5 years				
Patients aged 6 to 20				

31. How long does it typically take to hire or contract new staff for behavioral health services (consider time it takes to get a position approved and posted, interview candidates, and have a candidate accept the position and onboard)?

- 0 to 4 months
- 5 to 6 months
- 7 months or more

32. If there is a need to hire a billing-eligible behavioral health provider(s) to provide dyadic services during the grant period (including if there is an unanticipated staff transition and need to hire new staff during the grant), how would the service location meet the staffing requirement of having billing-eligible staff to provide dyadic services during the grant period? (200 word maximum).

Service locations participating in the grant will need to have staff allocated to support dyadic service implementation. This includes forming an implementation team consisting of 2-3 members, at minimum, to manage dyadic service implementation activities. Implementation team roles include a project lead and representation from medical primary care, behavioral health, and provider operations or practice management. An individual may serve in more than one role, for example a behavioral health provider may serve as both the project lead and behavioral health representative. The aim of the implementation team is to support planning, implementation, and quality improvement for dyadic services and dyadic billing.

To the best of your knowledge, provide information on who will be serving the key roles in the questions below.

33. Who will serve as the designated project lead for dyadic services (serves in a project management capacity and oversees day-to-day coordination and planning of dyadic care implementation and quality improvement)?

- Person identified. State name and title:
- Person not yet identified

34. Who will serve in the role of behavioral health representative (provides behavioral health perspective and collaborates on dyadic care implementation planning and delivery and workflow adaptations)?

- Person identified. State name and title:
- Person not yet identified

35. Who will serve in the role of medical provider representative (provides medical provider perspective and collaborates on dyadic care implementation planning and delivery and workflow adaptations)?

- Person identified. State name and title:
- Person not yet identified

36. Who or what team or department will be responsible for data collection and reporting for the grant?

- Identified. Name of entity:
- Not yet identified.

37. Who or what team or department will support billing and claims processing for Medi-Cal dyadic service codes?

- Identified. Name of entity:
- Not yet identified.

38. What medical record system does the service location use?

- Electronic health record/electronic medical record (EHR/EMR): Specify EHR/EMR system used:
- Paper medical records. Briefly describe process:
- Other. Specify:

39. In general, how easy is it for your clinic to implement changes in the service location's medical record system (such as documentation templates, creating structured data elements, loading new CPT codes)? (Select best fit).

- Extremely difficult- changes are slow and fully dependent on the vendor
- Somewhat difficult- most changes require external assistance
- Neither easy nor difficult

- Somewhat easy- minor changes are simple, but complex ones require support
- Very easy- changes can be made quickly by internal staff
- Not sure

40. What is the service location's staffing structure for data analysis and reporting? (Select best fit)

- No staff dedicated to data analytics, reporting, or quality improvement
- No formal role, responsibilities assigned on an ad hoc/as needed basis
- At least one identified staff member, but this is not their primary role
- At least one dedicated staff member whose primary role is data and/or quality improvement
- Dedicated team for data and quality improvement

41. How often does the service location generate reports for internal or external presentation? (Select best fit)

- Never
- Quarterly to annually
- Weekly to Monthly
- Real-time or automated dashboards
- Not sure

42. How often is data used for decision making? (Select best fit)

- Data is rarely used for decision making
- Data is reviewed occasionally but not routinely acted on
- Data is regularly reviewed and sometimes informs decisions
- Data is consistently used and drives operational or clinical decisions

43. How often is data used to assess and address disparities (such as by race, ethnicity, gender, language, geography)? (Select best fit)

- Never - Data is not used for assessing or addressing disparities.
- Rarely - Data is used occasionally, typically in response to specific requests or issues.

- Sometimes - Data is reviewed periodically, but not as part of a consistent process.
- Often - Data is regularly used to identify disparities and inform improvement efforts.
- Always - Data is routinely and systematically used to assess disparities, guide actions, and monitor progress.

IPAT REQUIREMENT FOR SINGLE-SERVICE LOCATION APPLICATIONS: THE IPAT 2.0 MUST BE COMPLETED TWICE – ONCE FOR PATIENTS AGED 6 YEARS AND OLDER AND ONCE FOR PATIENTS AGES 0-5 YEARS

44. IPAT 2.0: 6 years and older — Visit the National Council for Mental Wellbeing [webpage](#) for the full set of IPAT questions.

45. IPAT 2.0: Ages 0-5 years — Visit the National Council for Mental Wellbeing [webpage](#) for the full set of IPAT questions.

46. Does the practice location currently use an evidence-based dyadic care model (such as HealthySteps or Dulce)?

- Not currently using or considering using a model
- Currently using or considering using a model, specify model:

47. What phase of implementation is the service location in with the model? (Select best fit)

- Exploring or planning- Considering or planning to adopt a model but have not yet started services
- Early implementation- Pilot or limited use with some patients or staff or departments
- Partial implementation- Regular use in some teams or among some staff or departments, but not all components fully integrated or a routine part of care
- Full implementation-Fully integrated and being delivered to model specifications (all components in place and a routine part of care)
- Sustained- Fully integrated with ongoing evaluation and refinement

48. To the best of your knowledge, please choose the category that is the best fit for the current status and impact the grant would have on providing same-day behavioral well-child visits with embedded mental health professionals in pediatric primary care for early intervention and prevention (e.g. providing families with resources and guidance on child development, providing psycho-education focused on child-caregiver needs, offering coaching to strengthen parent-child interactions).

- Already or mostly established as routine care: This component is already a consistent or standard part of care; the grant would not meaningfully change its use.
- Currently not established and would not likely be established during the grant period: This component is currently not in place and would not likely be established during the grant period due to internal or external constraints.
- Minor impact: This component is not established or is partially established. The grant would provide only minor support to sustain or slightly enhance it.
- Moderate impact: This component is not currently in place or is partially in place. The grant would have a moderate impact on establishing this component as a sustained and routine part of care.
- Significant impact: This component is not currently in place or is partially in place. The grant would have a significant or critical impact on making this component a sustained and routine part of care.

49. To the best of your knowledge, please choose the category that is the best fit for the current status and impact the grant would have on having medical and behavioral health providers collaborate in real-time on patient care.

- Already or mostly established as routine care: This component is already a consistent, standard part of care; the grant would not meaningfully change its use.
- Currently not established and would not likely be established during the

grant period: This component is currently not in place and would not likely be established during the grant period due to internal or external constraints.

- Minor impact: This component is not established or is partially established. The grant would provide only minor support to sustain or slightly enhance it.
- Moderate impact: This component is not currently in place or is partially in place. The grant would have a moderate impact on establishing this component as a sustained and routine part of care.
- Significant impact: This component is not currently in place or is partially in place. The grant would have a significant or critical impact on making this component a sustained and routine part of care.

50. To the best of your knowledge, please choose the category that is the best fit for the current status and impact the grant would have on conducting universal screening for routine developmental, behavioral, and mental health screenings for all children to identify concerns early and address them proactively.

- Already or mostly established as routine care: This component is already a consistent, standard part of care; the grant would not meaningfully change its use.
- Currently not established and would not likely be established during the grant period: This component is currently not in place and would not likely be established during the grant period due to internal or external constraints.
- Minor impact: This component is not established or is partially established. The grant would provide only minor support to sustain or slightly enhance it.
- Moderate Impact: This component is not currently in place or is partially in place. The grant would have a moderate impact on establishing this component as a sustained and routine part of care.
- Significant impact - This component is not currently in place or is partially in place. The grant would have a significant or critical impact on making this component a sustained and routine part of care.

51. To the best of your knowledge, please choose the category that is the best fit for the current status and impact the grant would have on conducting universal caregiver mental health screening and support (screening parents for depression, anxiety, trauma, or other mental health concerns).

- Already or mostly established as routine care: This component is already a consistent, standard part of care; the grant would not meaningfully change its use.
- Currently not established and would not likely be established during the grant period: This component is currently not in place and would not likely be established during the grant period due to internal or external constraints.
- Minor impact: This component is not established or is partially established. The grant would provide only minor support to sustain or slightly enhance it.
- Moderate impact: This component is not currently in place or is partially in place. The grant would have a moderate impact on establishing this component as a sustained and routine part of care.
- Significant impact: This component is not currently in place or is partially in place. The grant would have a significant or critical impact on making this component a sustained and routine part of care.

52. To the best of your knowledge, please choose the category that is the best fit for the current status and impact the grant would have on providing brief intervention and referral to services for any needs identified from child and caregiver screening and assessment.

- Already or mostly established as routine care: This component is already a consistent, standard part of care; the grant would not meaningfully change its use.
- Currently not established and would not likely be established during the grant period: This component is currently not in place and would not likely be established during the grant period due to internal or external constraints.

- Minor impact: This component is not established or is partially established. The grant would provide only minor support to sustain or slightly enhance it.
- Moderate impact: This component is not currently in place or is partially in place. The grant would have a moderate impact on establishing this component as a sustained and routine part of care.
- Significant impact: This component is not currently in place or is partially in place. The grant would have a significant or critical impact on making this component a sustained and routine part of care.

53. To the best of your knowledge, please choose the category that is the best fit for the current status and impact the grant would have on supporting referrals and integrated services to address caregiver and family needs.

- Already or mostly established as routine care: This component is already a consistent, standard part of care; the grant would not meaningfully change its use.
- Currently not established and would not likely be established during the grant period: This component is currently not in place and would not likely be established during the grant period due to internal or external constraints.
- Minor impact: This component is not established or is partially established. The grant would provide only minor support to sustain or slightly enhance it.
- Moderate impact: This component is not currently in place or is partially in place. The grant would have a moderate impact on establishing this component as a sustained and routine part of care.
- Significant impact: This component is not currently in place or is partially in place. The grant would have a significant or critical impact on making this component a sustained and routine part of care.

54. To the best of your knowledge, please choose the category that is the best fit for the current status and impact the grant would have on conducting universal screening and assessment for Social Determinants of Health, identifying and addressing factors such as housing instability, food insecurity, or access to transportation that impact the health of children and families.

- Already or mostly established as routine care: This component is already a consistent, standard part of care; the grant would not meaningfully change its use.
- Currently not established and would not likely be established during the grant period: This component is currently not in place and would not likely be established during the grant period due to internal or external constraints.
- Minor impact: This component is not established or is partially established. The grant would provide only minor support to sustain or slightly enhance it.
- Moderate impact: This component is not currently in place or is partially in place. The grant would have a moderate impact on establishing this component as a sustained and routine part of care.
- Significant impact: This component is not currently in place or is partially in place. The grant would have a significant or critical impact on making this component a sustained and routine part of care.

55. To the best of your knowledge, please choose the category that is the best fit for the current status and impact the grant would have on providing family training & counseling in pediatric care for caregivers.

- Already or mostly established as routine care: This component is already a consistent, standard part of care; the grant would not meaningfully change its use.
- Currently not established and would not likely be established during the grant period: This component is currently not in place and would not likely be established during the grant period due to internal or external constraints.

- Minor impact: This component is not established or is partially established. The grant would provide only minor support to sustain or slightly enhance it.
- Moderate impact: This component is not currently in place or is partially in place. The grant would have a moderate impact on establishing this component as a sustained and routine part of care.
- Significant impact: This component is not currently in place or is partially in place. The grant would have a significant or critical impact on making this component a sustained and routine part of care.

56. To the best of your knowledge, please choose the category that is the best fit for the current status and impact the grant would have on collecting and evaluating population health data to identify gaps in care, track outcomes, and implement targeted interventions for specific groups within the practice.

- Already or mostly established as routine care: This component is already a consistent, standard part of care; the grant would not meaningfully change its use.
- Currently not established and would not likely be established during the grant period: This component is currently not in place and would not likely be established during the grant period due to internal or external constraints.
- Minor impact: This component is not established or is partially established. The grant would provide only minor support to sustain or slightly enhance it.
- Moderate impact: This component is not currently in place or is partially in place. The grant would have a moderate impact on establishing this component as a sustained and routine part of care.
- Significant impact: This component is not currently in place or is partially in place. The grant would have a significant or critical impact on making this component a sustained and routine part of care.

57. For the components listed above that were categorized as currently not established and not likely to be established during the grant or minor impact, please explain what would be needed to establish the component:

58. Overall, what best describes the service location's current experience with using Medi-Cal dyadic billing codes, in particular CPT code H1011 with modifier U1 for dyadic behavioral health visit? (Select best fit)

- Not familiar with Medi-Cal dyadic billing codes
- Aware of Medi-Cal dyadic billing codes but have not used them
- Have explored or attempted to use Medi-Cal dyadic billing codes
- Use Medi-Cal dyadic billing codes occasionally or inconsistently
- Routinely use Medi-Cal dyadic billing codes but billing is not yet a primary or sustained funding source
- Routinely use Medi-Cal dyadic billing codes and rely on them as a sustained funding source for dyadic services

POPULATION OF FOCUS AND NARRATIVE RESPONSES

The following question set collects information on the service location's population of focus and rationale for dyadic services through narrative statements.

59. Describe the target population for dyadic services (age groups, demographics) and the specific gaps and needs that dyadic services are intended to address within this population, including disparities in access and outcomes and how these relate to the identified target population. Include why dyadic services are a good fit for this population and anticipated impacts of dyadic services on patient care and/or practice operations (500 word maximum).

60. Describe the dyadic service components or approaches the service location aims to prioritize during the grant period and why. (250 word maximum).

61. Describe who will provide dyadic services (e.g., using existing staff, hiring new staff, and the percentage of staff time that will be dedicated to each age group). (200 word maximum).

62. Describe how the grant opportunity would increase or support the service location's dyadic service goals (250 word maximum).

REQUIRED DOCUMENT UPLOADS

The following section is for document uploads to complete the application. Name each document upload with the name of the service location followed by the document label. For example, a Leadership letter of Support from Main Street Clinic should be labeled "Main Street Clinic Leadership Letter of Support"

Required uploads include:

- Leadership Letter of Support
- Completed proposed budget for use of grant funds
- Resumes of program lead and other key staff (consolidated into one file for all resumes of key staff)
- Organizational Chart
- Audited Financial Statement
- W-9 Form
- Certificate of Insurance
- Federally Approved Indirect Rate Cost Letter, if applicable.

63. File upload: Letter of Support from executive leadership (Practice Director, CEO, or other entity that has authority to institute change and allocate resources). The Leadership Letter of Support should include:

- A description of the leader's level and role within the organization/practice
- Their commitment to the initiative, including any specific actions already taken
- How the leader plans to support dyadic care implementation and sustainability (e.g., resource allocation, percent of protected staff time that will be allocated for administration activities)

- 64. File Upload: Proposed budget for use of grant funds.**
- 65. File Upload: Curriculum vitae or resumes of program lead and other key staff (upload one consolidated file with all resumes).**
- 66. File Upload: Organizational Chart.**
- 67. File Upload: Audited Financial Statement.**
- 68. File Upload: W-9 Form.**
- 69. File Upload: Certificate of Insurance.**
- 70. File Upload: Federally Approved Indirect Rate Cost Letter, if applicable.**
- 71. By submitting this application, I agree that the information provided in this application is true and accurate to the best of my knowledge.**
 - Agree and submit
 - Do not agree and withdraw

Multi-Service Location Application

1. Please indicate the funding Tier to which the applicant is applying:

- Tier 1: Large provider service location: the service locations combined serve greater than or equal to 1,000 Medi-Cal children aged 0 to 5 years and with a partnership expected scope of a full-time staffing model dedicated to dyadic services, including 1.0 FTE or 100% of a full-time staff member dedicated to the target population in the provision of dyadic care (ages 0-5)
- Tier 2: Small to Medium Provider Service Location, the service locations combined serve greater than or equal to 500 Medi-Cal children aged 0 to 5 years and with a partnership expected scope of a part-time or phased staffing model, including 0.50 FTE or 50% of a full-time staff member dedicated to the target population in provision of dyadic care (ages 0-5)

2. Who is the point of contact and their contact information for this grant application?

- First name
- Last Name
- Title/role in organization
- Email
- Phone

3. What is the name and contact information for the PRIMARY service location applying for the grant? (The primary service location serves as the Grantee of Record and responsible for: Receiving and administering grant funds; coordinating implementation across participating provider service locations; and ensuring compliance with all grant requirements).

- Service Location Name
- Address
- Address 2
- City

- State
- Zip code

4. What is the Medi-Cal designation of the PRIMARY service location applying for the grant?

- Federally Qualified Health Center (FQHC)
- Rural Health Clinic (RHC)
- Indian Health Care Providers (IHCPs)
- Hospital-affiliated health system, specify:
- Community-based organization that operates Medi-Cal enrolled primary care clinics
- Other, specify

5. In order to be considered for the grant opportunity, a Medi-Cal Non-Specialty Mental Health Services (NSMHS) contract must be in place with at least one managed care provider (MCP) at the start of the grant period. What is the current contract status for Medi-Cal NSMHS for the primary service location applying?

- Fully contracted or in the process of contracting for Medi-Cal NSMHS with at least one MCP
- Not currently contracted or in the process of contracting for Medi-Cal NSMHS with any MCP

6. For the PRIMARY service location, which Managed Care Plan providers are contracted or in the process of being contracted for Medi-Cal NSMHS? (select all that apply and their corresponding Medi-Cal NSMHS contract status).

Category	Contract in place for Medi-Cal NSMHS	In the process of contracting for Medi-Cal NSMHS
Anthem Blue Cross Partnership Plan		
Blue Shield of California Promise Health Plan		
Health Net Community Solutions		
Molina Healthcare of California		
Kaiser Permanente (Medi-Cal)		
Partnership HealthPlan of California		
Local/county plan, specify:		
Other, specify:		

7. What is the name and contact information for the SECONDARY service location applying for the grant?

- ☐ Service Location Name
- ☐ Address
- ☐ Address 2
- ☐ City
- ☐ State
- ☐ Zip code

8. What is the Medi-Cal designation of the SECONDARY service location applying for the grant?

- Federally Qualified Health Center (FQHC)
- Rural Health Clinic (RHC)
- Indian Health Care Providers (IHCPs)
- Hospital-affiliated health system, specify:
- Community-based organization that operates Medi-Cal enrolled primary care clinics
- Other, specify

9. In order to be considered for the grant opportunity, a Medi-Cal Non-Specialty Mental Health Services (NSMHS) contract must be in place with at least one managed care provider (MCP) at the start of the grant period. What is the current contract status for Medi-Cal NSMHS for the SECONDARY service location applying?

- Fully contracted or in the process of contracting for Medi-Cal NSMHS with at least one MCP
- Not currently contracted or in the process of contracting for Medi-Cal NSMHS with any MCP

10. For the SECONDARY service location, which Managed Care Plan providers are contracted or in the process of being contracted for Medi-Cal NSMHS? (select all that apply and their corresponding Medi-Cal NSMHS contract status).

Category	Contract in place for Medi-Cal NSMHS	In the process of contracting for Medi-Cal NSMHS
Anthem Blue Cross Partnership Plan		
Blue Shield of California Promise Health Plan		
Health Net Community Solutions		
Molina Healthcare of California		
Kaiser Permanente (Medi-Cal)		
Partnership HealthPlan of California		
Local/county plan, specify:		
Other, specify:		

PATIENT POPULATION

The following set of questions collects information on the service locations' patient population.

11. For the PRIMARY service location, what is the primary county in which the majority of the PRIMARY service location's patients reside?

- ☐ Alameda County
- ☐ Alpine County
- ☐ Amador County
- ☐ Butte County

- Calaveras County
- Colusa County
- Contra Costa County
- Del Norte County
- El Dorado County
- Fresno County
- Glenn County
- Humboldt County
- Imperial County
- Inyo County
- Kern County
- Kings County
- Lake County
- Lassen County
- Los Angeles County
- Madera County
- Marin County
- Mariposa County
- Mendocino County
- Merced County
- Modoc County
- Mono County
- Monterey County
- Napa County
- Nevada County
- Orange County
- Placer County

- Plumas County
- Riverside County
- Sacramento County
- San Benito County
- San Bernardino County
- San Diego County
- San Francisco County
- San Joaquin County
- San Luis Obispo County
- San Mateo County
- Santa Barbara County
- Santa Clara County
- Santa Cruz County
- Shasta County
- Sierra County
- Siskiyou County
- Solano County
- Sonoma County
- Stanislaus County
- Sutter County
- Tehama County
- Trinity County
- Tulare County
- Tuolumne County
- Ventura County
- Yolo County
- Yuba County

12. For the SECONDARY service location, what is the primary county in which the majority of the SECONDARY service location's patients reside?

- Alameda County
- Alpine County
- Amador County
- Butte County
- Calaveras County
- Colusa County
- Contra Costa County
- Del Norte County
- El Dorado County
- Fresno County
- Glenn County
- Humboldt County
- Imperial County
- Inyo County
- Kern County
- Kings County
- Lake County
- Lassen County
- Los Angeles County
- Madera County
- Marin County
- Mariposa County
- Mendocino County
- Merced County
- Modoc County

- Mono County
- Monterey County
- Napa County
- Nevada County
- Orange County
- Placer County
- Plumas County
- Riverside County
- Sacramento County
- San Benito County
- San Bernardino County
- San Diego County
- San Francisco County
- San Joaquin County
- San Luis Obispo County
- San Mateo County
- Santa Barbara County
- Santa Clara County
- Santa Cruz County
- Shasta County
- Sierra County
- Siskiyou County
- Solano County
- Sonoma County
- Stanislaus County
- Sutter County
- Tehama County

- Trinity County
- Tulare County
- Tuolumne County
- Ventura County
- Yolo County
- Yuba County

13. Annual well-child visit count: What is the approximate total annual well-child and adolescent well-care visit count for the most recent calendar year for each of the service locations?

Category	Primary Service Location	Secondary Service Location
Annual well-child visits among patients aged 0 to 5 years		
Annual well-child visits among patients 6 to 20 years		
Total		

14.Count of total patients served: What is the total number of patients served by each of the service locations (count of all patients regardless of insurance status) by the following age groups?

Category	Primary Service Location	Secondary Service Location
Patients aged 0 to 5 years		
Patients aged 6 to 20 years		
Patients aged 21 years or more		
Total		

15.Count of patients enrolled in Medi-Cal: What is the total number of patients served who are enrolled in Medi-Cal at each of the service locations by the following age groups?

Category	Medi-Cal enrolled patients aged 0 to 5 years	Medi-Cal enrolled patients aged 6 to 20 years	Medi-Cal enrolled patients aged 21 years or more
Primary Service Location			
Secondary Service Location			

16.For each of the service locations, what is the percentage distribution of Medi-Cal enrolled pediatric patients (patients aged 0 to 20 years) by race for the following categories? The percent distributions must total to 100.

Category	% American Indian or Alaska Native	% Asian	% Black or African American	% Native Hawaiian or other Pacific Islander	% White	% Two or more races	% Other/declined/unknown
Primary Service Location							
Secondary Service Location							

17. For each of the service locations, what is the percentage distribution of Medi-Cal enrolled pediatric patients (patients aged 0 to 20 years) by ethnicity for the following categories? The percent distributions must total to 100.

Category	% Hispanic or Latino	% Not Hispanic or Latino	% Declined/ unknown/ not reported
Primary Service Location			
Secondary Service Location			

PRIMARY SERVICE LOCATION

The following question set collects information for the PRIMARY service location.

18. For the PRIMARY service location, what percent of the Medi-Cal enrolled pediatric patient population is best served in a language other than English?

- ☐ Less than 5%
- ☐ Greater than or equal to 5% and less than or equal to 25%
- ☐ Greater than 25% and less than or equal to 50%
- ☐ Greater than 50% and less than or equal to 75%
- ☐ Greater than 75%

19. What best describes how the PRIMARY service location supports language needs?

- ☐ No formal approach to supporting language needs
- ☐ Use primarily ad hoc or informal solutions, such as informal interpretation by staff or family members
- ☐ Use some formal supports, such as interpreters or translated materials for certain services or populations
- ☐ Use standardized language access services, such as professional interpreters and translated materials across most services for common

patient languages

- Use comprehensive, proactive language access strategies, such as staffing for language needs, standardized translation services, data tracking, and continuous improvement to support language access

20. Which of the following best describes the PRIMARY service location's approach to community engagement for provider services? Select the option that best reflects current practice, not future goals.

- Community input is not routinely gathered to inform services or programs
- Community members provide feedback on existing services, programs, or materials, but do not participate in decision-making
- Community members are consulted at key stages of planning or implementation, and their input may inform decisions
- Community members are engaged on an ongoing basis in program planning, implementation, or evaluation through defined advisory or partnership roles
- Community members share decision-making authority and participate in governance or leadership structures related to services or programs

21. Which structure(s) does the PRIMARY service location currently use to support community engagement? (Select all that apply)

- Surveys or feedback tools
- Periodic listening sessions, focus groups, or interviews
- Community advisory board
- Paid roles (permanent or temporary for a defined role or task)
- Other

SECONDARY SERVICE LOCATION

The following question set collects information for the SECONDARY service location.

22. For the SECONDARY service location, what percent of the Medi-Cal enrolled pediatric patient population is best served in a language other than English?

- ☐ Less than 5%
- ☐ Greater than or equal to 5% and less than or equal to 25%
- ☐ Greater than 25% and less than or equal to 50%
- ☐ Greater than 50% and less than or equal to 75%
- ☐ Greater than 75%

23. What best describes how the SECONDARY service location supports language needs?

- ☐ No formal approach to supporting language needs
- ☐ Use primarily ad hoc or informal solutions, such as informal interpretation by staff or family members
- ☐ Use some formal supports, such as interpreters or translated materials for certain services or populations
- ☐ Use standardized language access services, such as professional interpreters and translated materials across most services for common patient languages
- ☐ Use comprehensive, proactive language access strategies, such as staffing for language needs, standardized translation services, data tracking, and continuous improvement to support language access

24. Which of the following best describes the SECONDARY service location's approach to community engagement for provider services? Select the option that best reflects current practice, not future goals.

- ☐ Community input is not routinely gathered to inform services or programs
- ☐ Community members provide feedback on existing services, programs, or materials, but do not participate in decision-making
- ☐ Community members are consulted at key stages of planning or

implementation, and their input may inform decisions

- Community members are engaged on an ongoing basis in program planning, implementation, or evaluation through defined advisory or partnership roles
- Community members share decision-making authority and participate in governance or leadership structures related to services or programs

25. Which structure(s) does the SECONDARY service location currently use to support community engagement? (Select all that apply)

- Surveys or feedback tools
- Periodic listening sessions, focus groups, or interviews
- Community advisory board
- Paid roles (permanent or temporary for a defined role or task)
- Other (please specify):

STAFFING AND SERVICE LOCATION OFFERINGS

The following set of questions collects information on staffing and service location offerings for the PRIMARY service location.

26. For the PRIMARY service location, what is the total combined number of non-duplicated medical providers currently providing primary care services (on staff or contracted). Include MDs, NPs, DOs, PAs who conduct primary care visits:

27. For the PRIMARY service location, what is the total workload in full-time equivalent (FTE) among the medical providers allocated for primary care services for the following age groups.

(For FTE conversion: 1 staff with 100% of their time dedicated to services to a particular age group would equal 1.0 FTE, whereas 1 staff with 50% of their time dedicated to services to a particular age group would equal 0.50 FTE).

- Patients aged 0 to 5 years:
- Patients aged 6 to 20 years:
- Patients aged 21 years or more:
- Total:

28. For the PRIMARY service location, are there currently behavioral health providers who are eligible to bill for dyadic services on staff or contracted to provide behavioral health services? If yes, provide the total number of behavioral health providers who are eligible to bill for dyadic services.

Note: Behavioral health providers do not need to be currently providing dyadic services to count. Include any behavioral health provider whose provider type is eligible to bill for dyadic services, regardless of whether they currently provide them.

Provider types eligible to bill for dyadic services include:

- Physicians (MD/DO)
 - Licensed Clinical Social Workers (LCSWs)
 - Licensed Professional Clinical Counselors (LPCCs)
 - Licensed Marriage and Family Therapists (LMFTs)
 - Psychiatric Physician Assistants (PAs)
 - Psychiatric Nurse Practitioners (NPs)
 - Licensed Psychologists
 - Associate Marriage and Family Therapists (AMFTs)
 - Associate Professional Clinical Counselors (APCCs)
 - Associate Clinical Social Workers (ASWs)
 - Psychological Associates
- » Yes , total number of behavioral health providers eligible to bill for dyadic services who are on staff or contracted:
- » No

29. Primary Service Location: For each age group below, indicate the availability of behavioral health providers who are eligible to bill for dyadic services and are on staff or contracted to provide behavioral health services to patients in that age group.

Note: Behavioral health providers do not need to be currently providing dyadic services.

If yes, enter the total provider full-time equivalent (FTE) allocated to serving patients in that age group. Include only FTE from providers who are eligible to bill for dyadic services.

FTE examples:

- One provider dedicating 100% of their time to behavioral health services for an age group = 1.0 FTE
- One provider dedicating 50% of their time= 0.5 FTE total
- Two providers each dedicating 25% of their time= 0.5 FTE total

Category	Any behavioral health provider time allocated to this age group?		Total FTE for Behavioral Health Services
	Yes	No	
Category Responses			FTE
Patients aged 0 to 5 years			
Patients aged 6 to 20			
Patients aged 21 years or more			

30. Does the PRIMARY service location have any formal partnerships with graduate training programs, academic institutions, or other behavioral health workforce training programs?

- Yes, specify program:
- No

31. Does the PRIMARY service location provide training and supervision for trainees or associate-level clinicians?

- ☐ Yes
- ☐ No

32. What trainee or license-eligible roles are currently supported or supervised at the PRIMARY service location? (Check all that apply)

- ☐ Graduate student (marriage and family therapist trainee or social work trainee still enrolled in school)
- ☐ Associate Marriage and Family Therapist
- ☐ Associate Social Worker
- ☐ Psychology postdoctoral intern
- ☐ Postdoctoral fellow
- ☐ Other, please specify

33. What is the total non-duplicated count of trainees supported at the PRIMARY service location in a year, on average?

34. What is the total workload in full-time equivalent (FTE) among behavioral health trainees for the following age groups.

(For FTE conversion: 1 staff with 100% of their time dedicated to services to a particular age group would equal 1.0 FTE, whereas 1 staff with 50% of their time dedicated to services to a particular age group would equal 0.50 FTE).

- ☐ Patients aged 0 to 5 years:
- ☐ Patients aged 6 to 20 years:
- ☐ Patients aged 21 years or more:
- ☐ Total:

35. What is the total non-duplicated count of supervisors for behavioral health trainees at the PRIMARY service location?

36. What is the total workload in full-time equivalent (FTE) for supervisors dedicated to supervision of behavioral health trainees for the following age groups.

(For FTE conversion: 1 staff with 100% of their time dedicated to services to a particular age group would equal 1.0 FTE, whereas 1 staff with 50% of their time dedicated to services to a particular age group would equal 0.50 FTE).

- Patients aged 0 to 5 years:
- Patients aged 6 to 20 years:
- Patients aged 21 years or more:
- Total:

STAFFING AND SERVICE LOCATION OFFERINGS

The following set of questions collects information on staffing and service location offerings for the SECONDARY service location.

37. For the SECONDARY service location, what is the total combined number of non-duplicated medical providers currently providing primary care services (on staff or contracted). Include MDs, NPs, DOs, PAs who conduct primary care visits:

38. For the SECONDARY service location, what is the total workload in full-time equivalent (FTE) among the medical providers allocated for primary care services for the following age groups.

(For FTE conversion: 1 staff with 100% of their time dedicated to services to a particular age group would equal 1.0 FTE, whereas 1 staff with 50% of their time dedicated to services to a particular age group would equal 0.50 FTE).

- Patients aged 0 to 5 years:
- Patients aged 6 to 20 years:
- Patients aged 21 years or more:
- Total:

39. For the SECONDARY service location, are there currently behavioral health providers who are eligible to bill for dyadic services on staff or contracted to provide behavioral health services? If yes, provide the total number of behavioral health service providers who are eligible to bill for dyadic services.

Note: Behavioral health providers do not need to be currently providing dyadic services to count. Include any behavioral health provider whose provider type is eligible to bill for dyadic services, regardless of whether they currently provide them.

Provider types eligible to bill for dyadic services include:

- Physicians (MD/DO)
 - Licensed Clinical Social Workers (LCSWs)
 - Licensed Professional Clinical Counselors (LPCCs)
 - Licensed Marriage and Family Therapists (LMFTs)
 - Psychiatric Physician Assistants (PAs)
 - Psychiatric Nurse Practitioners (NPs)
 - Licensed Psychologists
 - Associate Marriage and Family Therapists (AMFTs)
 - Associate Professional Clinical Counselors (APCCs)
 - Associate Clinical Social Workers (ASWs)
 - Psychological Associates
- » Yes , total number of behavioral health providers eligible to bill for dyadic services who are on staff or contracted:
- » No

40. Secondary Service Location: For each age group below, indicate the availability of behavioral health providers who are eligible to bill for dyadic services and are on staff or contracted to provide behavioral health services to patients in that age group.

Note: Behavioral health providers do not need to be currently providing dyadic services.

If yes, enter the total provider full-time equivalent (FTE) allocated to serving patients in that age group. Include only FTE from providers who are eligible to bill for dyadic services.

FTE examples:

- » One provider dedicating 100% of their time to behavioral health services for an age group = 1.0 FTE
- » One provider dedicating 50% of their time= 0.5 FTE total
- » Two providers each dedicating 25% of their time= 0.5 FTE total

Category	Any behavioral health provider time allocated to this age group?		Total FTE for Behavioral Health Services
	Yes	No	FTE
Category Responses			
Patients aged 0 to 5 years			
Patients aged 6 to 20			
Patients aged 21 years or more			

41.Does the SECONDARY service location have any formal partnerships with graduate training programs, academic institutions, or other behavioral health workforce training programs?

- Yes, specify program:
- No

42. Does the SECONDARY service location provide training and supervision for trainees or associate-level clinicians?

- ☐ Yes
- ☐ No

43. What trainee or license-eligible roles are currently supported or supervised at the SECONDARY service location? (Check all that apply)

- ☐ Graduate student (marriage and family therapist trainee or social work trainee still enrolled in school)
- ☐ Associate Marriage and Family Therapist
- ☐ Associate Social Worker
- ☐ Psychology postdoctoral intern
- ☐ Postdoctoral fellow
- ☐ Other, please specify

44. What is the total non-duplicated count of trainees supported at the SECONDARY service location in a year, on average?

45. What is the total workload in full-time equivalent (FTE) among behavioral health trainees for the following age groups (For FTE conversion: 1 staff with 100% of their time dedicated to services to a particular age group would equal 1.0 FTE, whereas 1 staff with 50% of their time dedicated to services to a particular age group would equal 0.50 FTE)?

- ☐ Patients aged 0 to 5 years:
- ☐ Patients aged 6 to 20 years:
- ☐ Patients aged 21 years or more:
- ☐ Total:

46. What is the total non-duplicated count of supervisors for behavioral health trainees at the SECONDARY service location?

47. What is the total workload in full-time equivalent (FTE) for supervisors dedicated to supervision of behavioral health trainees for the following age groups. (For FTE conversion: 1 staff with 100% of their time dedicated to services to a particular age group would equal 1.0 FTE, whereas 1 staff with 50% of their time dedicated to services to a particular age group would equal 0.50 FTE)

- Patients aged 0 to 5 years:
- Patients aged 6 to 20 years:
- Patients aged 21 years or more:
- Total:

DYADIC SERVICE IMPLEMENTATION SUPPORTS

The following set of questions collects information on dyadic service provider and implementation support roles for dyadic services for the grant program. Report information for the combined strategy for both the primary and secondary service location unless otherwise indicated in the question prompt.

48. Based on the definitions below, what best describes the service locations' staffing readiness to provide dyadic services using behavioral health providers who are eligible to bill for those services? For a full list of provider types eligible to bill for dyadic services, see the DHCS Dyadic Service Manual.

- **Fully in place**= Additional hiring or contracting of billing-eligible staff is not needed since existing billing-eligible staff is sufficient to support dyadic service implementation or expansion for the target age group, or needs can be met through re-allocation of existing billing-eligible behavioral health staff.
- **Mostly in place** = Some additional hiring or minor adjustments in staff allocation may be needed to meet expected demand for dyadic services, however existing billing-eligible staff is largely sufficient to support dyadic service implementation or expansion for the target age group.
- **Partially in place** = Some billing-eligible staff exist to provide dyadic services, but additional hiring or contracting of billing-eligible providers will be needed to meet expected demand.
- **Need to fully hire** = Will need to fully hire or contract billing-eligible

providers to provide dyadic services since billing-eligible staff are not in place to provide dyadic services and/or existing billing-eligible staff cannot be reallocated to support these services.

Category	Need to fully hire	Partially in Place	Mostly in Place	Fully in Place
Patients aged 0 to 5 years				
Patients aged 6 to 20				

49. How long does it typically take to hire or contract new staff for behavioral health services (consider time it takes to get a position approved and posted, interview candidates, and have a candidate accept the position and onboard)?

- 0 to 4 months
- 5 to 6 months
- 7 months or more

50. If there is a need to hire a billing-eligible behavioral health provider(s) to provide dyadic services during the grant period (including if there is an unanticipated staff transition and need to hire new staff during the grant), how would the service locations meet the staffing requirement of having billing-eligible staff to provide dyadic services during the grant period? (200 word Max)

SERVICE LOCATIONS PARTICIPATING IN THE GRANT WILL NEED TO HAVE STAFF ALLOCATED TO SUPPORT DYADIC SERVICE IMPLEMENTATION

Service locations participating in the grant will need to have staff allocated to support dyadic service implementation. This includes forming an implementation team consisting of 2-3 members, at minimum, to manage dyadic service implementation activities. Implementation team roles include a project lead and representation from medical primary care, behavioral health, and provider operations or practice management. An individual may serve in more than one role, for example a behavioral health provider may serve as both the project lead and behavioral health representative. The aim of the implementation team is to support planning, implementation, and quality improvement for dyadic services and dyadic billing.

To the best of your knowledge, provide information on the status of who will be serving the key roles in the questions below.

51. Who will serve as the designated project lead for dyadic services (serves in a project management capacity and oversees day-to-day coordination and planning of dyadic care implementation and quality improvement)?

- ☐ Person identified. State name and title:
- ☐ Person not yet identified

52. Who will serve in the role of behavioral health representative (provides behavioral health perspective and collaborates on dyadic care implementation planning and delivery and workflow adaptations)?

- ☐ Person identified. State name and title:
- ☐ Person not yet identified

53. Who will serve in the role of medical provider representative (provides medical provider perspective and collaborates on dyadic care implementation planning and delivery and workflow adaptations)?

- ☐ Person identified. State name and title:
- ☐ Person not yet identified

54. Who or what team or department will be responsible for data collection and reporting for the grant?

- Identified. Name of entity:
- Not yet identified.

55. Who or what team or department will support billing and claims processing for Medi-Cal dyadic service codes?

- Identified. Name of entity:
- Not yet identified.

THE FOLLOWING QUESTIONS WILL COLLECT INFORMATION FOR PRIMARY SERVICE LOCATION

The following questions will collect information for PRIMARY service location.

56. What medical record system does the PRIMARY service location use?

- Electronic health record/electronic medical record (EHR/EMR): Specify EHR/EMR system used:
- Paper medical records. Briefly describe process:
- Other. Specify:

57. In general, how easy is it for the PRIMARY service location to implement changes in the service location's medical record system (such as documentation templates, creating structured data elements, loading new CPT codes)? (Select best fit)

- Extremely difficult- changes are slow and fully dependent on the vendor
- Somewhat difficult- most changes require external assistance
- Neither easy nor difficult
- Somewhat easy- minor changes are simple, but complex ones require support
- Very easy- changes can be made quickly by internal staff
- Not sure

58. What is the PRIMARY service location's staffing structure for data analysis and reporting? (Select best fit)

- ☐ No staff dedicated to data analytics, reporting, or quality improvement
- ☐ No formal role, responsibilities assigned on an ad hoc/as needed basis
- ☐ At least one identified staff member, but this is not their primary role
- ☐ At least one dedicated staff member whose primary role is data and/or quality improvement
- ☐ Dedicated team for data and quality improvement

59. How often does the PRIMARY service location generate reports for internal or external presentation? (Select best fit)

- ☐ Never
- ☐ Quarterly to annually
- ☐ Weekly to Monthly
- ☐ Real-time or automated dashboards
- ☐ Not sure

60. At the PRIMARY service location, how often is data used for decision making? (Select best fit)

- ☐ Data is rarely used for decision making
- ☐ Data is reviewed occasionally but not routinely acted on
- ☐ Data is regularly reviewed and sometimes informs decisions
- ☐ Data is consistently used and drives operational or clinical decisions

61. For the PRIMARY service location, how often is data used to assess and address disparities (such as by race, ethnicity, gender, language, geography)? (Select best fit)

- ☐ Never -Data is not used for assessing or addressing disparities.
- ☐ Rarely - Data is used occasionally, typically in response to specific requests or issues.
- ☐ Sometimes - Data is reviewed periodically, but not as part of a consistent

process.

- Often - Data is regularly used to identify disparities and inform improvement efforts.
- Always - Data is routinely and systematically used to assess disparities, guide actions, and monitor progress.

THE FOLLOWING QUESTIONS WILL COLLECT INFORMATION FOR SECONDARY SERVICE LOCATION

The following questions will collect information for SECONDARY service location.

62. What medical record system does the SECONDARY service location use?

- Electronic health record/electronic medical record (EHR/EMR): Specify EHR/EMR system used:
- Paper medical records. Briefly describe process:
- Other. Specify:

63. In general, how easy is it for the SECONDARY service location to implement changes in the service location's medical record system (such as documentation templates, creating structured data elements, loading new CPT codes)? (Select best fit)

- Extremely difficult- changes are slow and fully dependent on the vendor
- Somewhat difficult- most changes require external assistance
- Neither easy nor difficult
- Somewhat easy- minor changes are simple, but complex ones require support
- Very easy- changes can be made quickly by internal staff
- Not sure

64. How often does the SECONDARY service location generate reports for internal or external presentation? (Select best fit)

- ☐ Never
- ☐ Quarterly to annually
- ☐ Weekly to Monthly
- ☐ Real-time or automated dashboards
- ☐ Not sure

65. What is the SECONDARY service location's staffing structure for data analysis and reporting? (Select best fit)

- ☐ No staff dedicated to data analytics, reporting, or quality improvement
- ☐ No formal role, responsibilities assigned on an ad hoc/as needed basis
- ☐ At least one identified staff member, but this is not their primary role
- ☐ At least one dedicated staff member whose primary role is data and/or quality improvement
- ☐ Dedicated team for data and quality improvement

66. At the SECONDARY service location, how often is data used for decision making? (Select best fit)

- ☐ Data is rarely used for decision making
- ☐ Data is reviewed occasionally but not routinely acted on
- ☐ Data is regularly reviewed and sometimes informs decisions
- ☐ Data is consistently used and drives operational or clinical decisions

67. For the SECONDARY service location, how often is data used to assess and address disparities (such as by race, ethnicity, gender, language, geography)? (Select best fit)

- ☐ Never -Data is not used for assessing or addressing disparities.
- ☐ Rarely - Data is used occasionally, typically in response to specific requests or issues.
- ☐ Sometimes - Data is reviewed periodically, but not as part of a consistent

process.

- Often - Data is regularly used to identify disparities and inform improvement efforts.
- Always - Data is routinely and systematically used to assess disparities, guide actions, and monitor progress.

IPAT REQUIREMENT FOR MULTI-SERVICE LOCATION APPLICATIONS: THE IPAT 2.0 MUST BE COMPLETED FOUR TIMES—ONCE FOR EACH SERVICE LOCATION FOR PATIENTS AGED 6 YEARS AND OLDER, AND ONCE FOR EACH SERVICE LOCATION FOR PATIENTS AGES 0-5 YEARS.

68. IPAT 2.0: PRIMARY service location, 6 years and older — Visit the National Council for Mental Wellbeing [webpage](#) for the full set of IPAT questions.

69. IPAT 2.0: PRIMARY service location, ages 0-5 years — Visit the National Council for Mental Wellbeing [webpage](#) for the full set of IPAT questions.

70. IPAT 2.0: SECONDARY service location, 6 years and older — Visit the National Council for Mental Wellbeing [webpage](#) for the full set of IPAT questions.

71. IPAT 2.0: SECONDARY service location, ages 0-5 years — Visit the National Council for Mental Wellbeing [webpage](#) for the full set of IPAT questions.

THE FOLLOWING SET OF QUESTIONS COLLECTS INFORMATION FOR THE PRIMARY SERVICE LOCATION

The following set of questions collects information for the PRIMARY service location.

72. Does the PRIMARY service location currently use an evidence-based dyadic care model (such as HealthySteps or Dulce)?

- Not currently using or considering using a model
- Currently using or considering using a model, specify model:

73. What phase of implementation is the PRIMARY service location in with the model? (Select best fit).

- Exploring or planning- Considering or planning to adopt a model but have not yet started services
- Early implementation- Pilot or limited use with some patients or staff or departments
- Partial implementation- Regular use in some teams or among some staff or departments, but not all components fully integrated or a routine part of care
- Full implementation-Fully integrated and being delivered to model specifications (all components in place and a routine part of care)
- Sustained- Fully integrated with ongoing evaluation and refinement

74. For the PRIMARY service location: To the best of your knowledge, please choose the category that is the best fit for the current status and impact the grant would have on providing same-day behavioral well-child visits with embedded mental health professionals in pediatric primary care for early intervention and prevention (e.g. providing families with resources and guidance on child development, providing psycho-education focused on child-caregiver needs, offering coaching to strengthen parent-child interactions).

- Already or mostly established as routine care: This component is already a consistent or standard part of care; the grant would not meaningfully change its use.
- Currently not established and would not likely be established during the grant period: This component is currently not in place and would not likely be established during the grant period due to internal or external constraints.
- Minor impact: This component is not established or is partially established. The grant would provide only minor support to sustain or slightly enhance it.
- Moderate impact: This component is not currently in place or is partially in place. The grant would have a moderate impact on establishing this component as a sustained and routine part of care.

- Significant impact: This component is not currently in place or is partially in place. The grant would have a significant or critical impact on making this component a sustained and routine part of care.

75. For the PRIMARY service location: To the best of your knowledge, please choose the category that is the best fit for the current status and impact the grant would have on having medical and behavioral health providers collaborate in real-time on patient care.

- Already or mostly established as routine care: This component is already a consistent, standard part of care; the grant would not meaningfully change its use.
- Currently not established and would not likely be established during the grant period: This component is currently not in place and would not likely be established during the grant period due to internal or external constraints.
- Minor impact: This component is not established or is partially established. The grant would provide only minor support to sustain or slightly enhance it.
- Moderate impact: This component is not currently in place or is partially in place. The grant would have a moderate impact on establishing this component as a sustained and routine part of care.
- Significant impact: This component is not currently in place or is partially in place. The grant would have a significant or critical impact on making this component a sustained and routine part of care.

76. For the PRIMARY service location: To the best of your knowledge, please choose the category that is the best fit for the current status and impact the grant would have on conducting universal screening for routine developmental, behavioral, and mental health screenings for all children to identify concerns early and address them proactively.

- Already or mostly established as routine care: This component is already a consistent, standard part of care; the grant would not meaningfully change its use.
- Currently not established and would not likely be established during the grant period: This component is currently not in place and would not likely

be established during the grant period due to internal or external constraints.

- Minor impact: This component is not established or is partially established. The grant would provide only minor support to sustain or slightly enhance it.
- Moderate Impact: This component is not currently in place or is partially in place. The grant would have a moderate impact on establishing this component as a sustained and routine part of care.
- Significant impact - This component is not currently in place or is partially in place. The grant would have a significant or critical impact on making this component a sustained and routine part of care.

77. For the PRIMARY service location: To the best of your knowledge, please choose the category that is the best fit for the current status and impact the grant would have on conducting universal caregiver mental health screening and support (screening parents for depression, anxiety, trauma, or other mental health concerns).

- Already or mostly established as routine care: This component is already a consistent, standard part of care; the grant would not meaningfully change its use.
- Currently not established and would not likely be established during the grant period: This component is currently not in place and would not likely be established during the grant period due to internal or external constraints.
- Minor impact: This component is not established or is partially established. The grant would provide only minor support to sustain or slightly enhance it.
- Moderate impact: This component is not currently in place or is partially in place. The grant would have a moderate impact on establishing this component as a sustained and routine part of care.
- Significant impact: This component is not currently in place or is partially in place. The grant would have a significant or critical impact on making this component a sustained and routine part of care.

78. For the PRIMARY service location: To the best of your knowledge, please choose the category that is the best fit for the current status and impact the grant would have on providing brief intervention and referral to services for any needs identified from child and caregiver screening and assessment.

- Already or mostly established as routine care: This component is already a consistent, standard part of care; the grant would not meaningfully change its use.
- Currently not established and would not likely be established during the grant period: This component is currently not in place and would not likely be established during the grant period due to internal or external constraints.
- Minor impact: This component is not established or is partially established. The grant would provide only minor support to sustain or slightly enhance it.
- Moderate impact: This component is not currently in place or is partially in place. The grant would have a moderate impact on establishing this component as a sustained and routine part of care.
- Significant impact: This component is not currently in place or is partially in place. The grant would have a significant or critical impact on making this component a sustained and routine part of care.

79. For the PRIMARY service location: To the best of your knowledge, please choose the category that is the best fit for the current status and impact the grant would have on supporting referrals and integrated services to address caregiver and family needs.

- Already or mostly established as routine care: This component is already a consistent, standard part of care; the grant would not meaningfully change its use.
- Currently not established and would not likely be established during the grant period: This component is currently not in place and would not likely be established during the grant period due to internal or external constraints.
- Minor impact: This component is not established or is partially established.

The grant would provide only minor support to sustain or slightly enhance it.

- Moderate impact: This component is not currently in place or is partially in place. The grant would have a moderate impact on establishing this component as a sustained and routine part of care.
- Significant impact: This component is not currently in place or is partially in place. The grant would have a significant or critical impact on making this component a sustained and routine part of care.

80. For the PRIMARY service location: To the best of your knowledge, please choose the category that is the best fit for the current status and impact the grant would have on conducting universal screening and assessment for Social Determinants of Health, identifying and addressing factors such as housing instability, food insecurity, or access to transportation that impact the health of children and families.

- Already or mostly established as routine care: This component is already a consistent, standard part of care; the grant would not meaningfully change its use.
- Currently not established and would not likely be established during the grant period: This component is currently not in place and would not likely be established during the grant period due to internal or external constraints.
- Minor impact: This component is not established or is partially established. The grant would provide only minor support to sustain or slightly enhance it.
- Moderate impact: This component is not currently in place or is partially in place. The grant would have a moderate impact on establishing this component as a sustained and routine part of care.
- Significant impact: This component is not currently in place or is partially in place. The grant would have a significant or critical impact on making this component a sustained and routine part of care.

81. For the PRIMARY service location: To the best of your knowledge, please choose the category that is the best fit for the current status and impact the grant would have on providing family training & counseling in pediatric care for caregivers.

- Already or mostly established as routine care: This component is already a consistent, standard part of care; the grant would not meaningfully change its use.
- Currently not established and would not likely be established during the grant period: This component is currently not in place and would not likely be established during the grant period due to internal or external constraints.
- Minor impact: This component is not established or is partially established. The grant would provide only minor support to sustain or slightly enhance it.
- Moderate impact: This component is not currently in place or is partially in place. The grant would have a moderate impact on establishing this component as a sustained and routine part of care.
- Significant impact: This component is not currently in place or is partially in place. The grant would have a significant or critical impact on making this component a sustained and routine part of care.

82. For the PRIMARY service location: To the best of your knowledge, please choose the category that is the best fit for the current status and impact the grant would have on collecting and evaluating population health data to identify gaps in care, track outcomes, and implement targeted interventions for specific groups within the practice.

- Already or mostly established as routine care: This component is already a consistent, standard part of care; the grant would not meaningfully change its use.
- Currently not established and would not likely be established during the grant period: This component is currently not in place and would not likely be established during the grant period due to internal or external constraints.

- Minor impact: This component is not established or is partially established. The grant would provide only minor support to sustain or slightly enhance it.
- Moderate impact: This component is not currently in place or is partially in place. The grant would have a moderate impact on establishing this component as a sustained and routine part of care.
- Significant impact: This component is not currently in place or is partially in place. The grant would have a significant or critical impact on making this component a sustained and routine part of care.

83. For any of the components listed above that were categorized as currently not established and not likely to be established during the grant or minor impact, please explain what would be needed to establish the component:

84. For the PRIMARY service location: Overall, what best describes the primary service location's current experience with using Medi-Cal dyadic billing codes, in particular CPT code H1011 with modifier U1 for dyadic behavioral health visit? (Select best fit)

- Not familiar with Medi-Cal dyadic billing codes
- Aware of Medi-Cal dyadic billing codes but have not used them
- Have explored or attempted to use Medi-Cal dyadic billing codes
- Use Medi-Cal dyadic billing codes occasionally or inconsistently
- Routinely use Medi-Cal dyadic billing codes but billing is not yet a primary or sustained funding source
- Routinely use Medi-Cal dyadic billing codes and rely on them as a sustained funding source for dyadic services

THE FOLLOWING SET OF QUESTIONS COLLECTS INFORMATION FOR THE SECONDARY SERVICE LOCATION

The following set of questions collects information for the SECONDARY service location.

85. Does the SECONDARY service location currently use an evidence-based dyadic care model (such as HealthySteps or Dulce)?

- Not currently using or considering using a model
- Currently using or considering using a model, specify model:

86. What phase of implementation is the SECONDARY service location in with the model? (Select best fit)

- Exploring or planning- Considering or planning to adopt a model but have not yet started services
- Early implementation- Pilot or limited use with some patients or staff or departments
- Partial implementation- Regular use in some teams or among some staff or departments, but not all components fully integrated or a routine part of care
- Full implementation-Fully integrated and being delivered to model specifications (all components in place and a routine part of care)
- Sustained- Fully integrated with ongoing evaluation and refinement

87. For the SECONDARY service location: To the best of your knowledge, please choose the category that is the best fit for the current status and impact the grant would have on providing same-day behavioral well-child visits with embedded mental health professionals in pediatric primary care for early intervention and prevention (e.g. providing families with resources and guidance on child development, providing psycho-education focused on child-caregiver needs, offering coaching to strengthen parent-child interactions).

- Already or mostly established as routine care: This component is already a consistent or standard part of care; the grant would not meaningfully change its use.

- Currently not established and would not likely be established during the grant period: This component is currently not in place and would not likely be established during the grant period due to internal or external constraints.
- Minor impact: This component is not established or is partially established. The grant would provide only minor support to sustain or slightly enhance it.
- Moderate impact: This component is not currently in place or is partially in place. The grant would have a moderate impact on establishing this component as a sustained and routine part of care.
- Significant impact: This component is not currently in place or is partially in place. The grant would have a significant or critical impact on making this component a sustained and routine part of care.

88. For the SECONDARY service location: To the best of your knowledge, please choose the category that is the best fit for the current status and impact the grant would have on having medical and behavioral health providers collaborate in real-time on patient care.

- Already or mostly established as routine care: This component is already a consistent, standard part of care; the grant would not meaningfully change its use.
- Currently not established and would not likely be established during the grant period: This component is currently not in place and would not likely be established during the grant period due to internal or external constraints.
- Minor impact: This component is not established or is partially established. The grant would provide only minor support to sustain or slightly enhance it.
- Moderate impact: This component is not currently in place or is partially in place. The grant would have a moderate impact on establishing this component as a sustained and routine part of care.
- Significant impact: This component is not currently in place or is partially in place. The grant would have a significant or critical impact on making this component a sustained and routine part of care.

89. For the SECONDARY service location: To the best of your knowledge, please choose the category that is the best fit for the current status and impact the grant would have on conducting universal screening for routine developmental, behavioral, and mental health screenings for all children to identify concerns early and address them proactively.

- Already or mostly established as routine care: This component is already a consistent, standard part of care; the grant would not meaningfully change its use.
- Currently not established and would not likely be established during the grant period: This component is currently not in place and would not likely be established during the grant period due to internal or external constraints.
- Minor impact: This component is not established or is partially established. The grant would provide only minor support to sustain or slightly enhance it.
- Moderate Impact: This component is not currently in place or is partially in place. The grant would have a moderate impact on establishing this component as a sustained and routine part of care.
- Significant impact - This component is not currently in place or is partially in place. The grant would have a significant or critical impact on making this component a sustained and routine part of care.

90. For the SECONDARY service location: To the best of your knowledge, please choose the category that is the best fit for the current status and impact the grant would have on conducting universal caregiver mental health screening and support (screening parents for depression, anxiety, trauma, or other mental health concerns).

- Already or mostly established as routine care: This component is already a consistent, standard part of care; the grant would not meaningfully change its use.
- Currently not established and would not likely be established during the grant period: This component is currently not in place and would not likely be established during the grant period due to internal or external constraints.

- Minor impact: This component is not established or is partially established. The grant would provide only minor support to sustain or slightly enhance it.
- Moderate impact: This component is not currently in place or is partially in place. The grant would have a moderate impact on establishing this component as a sustained and routine part of care.
- Significant impact: This component is not currently in place or is partially in place. The grant would have a significant or critical impact on making this component a sustained and routine part of care.

91. For the SECONDARY service location: To the best of your knowledge, please choose the category that is the best fit for the current status and impact the grant would have on providing brief intervention and referral to services for any needs identified from child and caregiver screening and assessment.

- Already or mostly established as routine care: This component is already a consistent, standard part of care; the grant would not meaningfully change its use.
- Currently not established and would not likely be established during the grant period: This component is currently not in place and would not likely be established during the grant period due to internal or external constraints.
- Minor impact: This component is not established or is partially established. The grant would provide only minor support to sustain or slightly enhance it.
- Moderate impact: This component is not currently in place or is partially in place. The grant would have a moderate impact on establishing this component as a sustained and routine part of care.
- Significant impact: This component is not currently in place or is partially in place. The grant would have a significant or critical impact on making this component a sustained and routine part of care.

92. For the SECONDARY service location: To the best of your knowledge, please choose the category that is the best fit for the current status and impact the grant would have on supporting referrals and integrated services to address caregiver and family needs.

- Already or mostly established as routine care: This component is already a consistent, standard part of care; the grant would not meaningfully change its use.
- Currently not established and would not likely be established during the grant period: This component is currently not in place and would not likely be established during the grant period due to internal or external constraints.
- Minor impact: This component is not established or is partially established. The grant would provide only minor support to sustain or slightly enhance it.
- Moderate impact: This component is not currently in place or is partially in place. The grant would have a moderate impact on establishing this component as a sustained and routine part of care.
- Significant impact: This component is not currently in place or is partially in place. The grant would have a significant or critical impact on making this component a sustained and routine part of care.

93. For the SECONDARY service location: To the best of your knowledge, please choose the category that is the best fit for the current status and impact the grant would have on conducting universal screening and assessment for Social Determinants of Health, identifying and addressing factors such as housing instability, food insecurity, or access to transportation that impact the health of children and families.

- Already or mostly established as routine care: This component is already a consistent, standard part of care; the grant would not meaningfully change its use.
- Currently not established and would not likely be established during the grant period: This component is currently not in place and would not likely be established during the grant period due to internal or external constraints.

- Minor impact: This component is not established or is partially established. The grant would provide only minor support to sustain or slightly enhance it.
- Moderate impact: This component is not currently in place or is partially in place. The grant would have a moderate impact on establishing this component as a sustained and routine part of care.
- Significant impact: This component is not currently in place or is partially in place. The grant would have a significant or critical impact on making this component a sustained and routine part of care.

94. For the SECONDARY service location: To the best of your knowledge, please choose the category that is the best fit for the current status and impact the grant would have on providing family training & counseling in pediatric care for caregivers.

- Already or mostly established as routine care: This component is already a consistent, standard part of care; the grant would not meaningfully change its use.
- Currently not established and would not likely be established during the grant period: This component is currently not in place and would not likely be established during the grant period due to internal or external constraints.
- Minor impact: This component is not established or is partially established. The grant would provide only minor support to sustain or slightly enhance it.
- Moderate impact: This component is not currently in place or is partially in place. The grant would have a moderate impact on establishing this component as a sustained and routine part of care.
- Significant impact: This component is not currently in place or is partially in place. The grant would have a significant or critical impact on making this component a sustained and routine part of care.

95. For the SECONDARY service location: To the best of your knowledge, please choose the category that is the best fit for the current status and impact the grant would have on collecting and evaluating population health data to identify gaps in care, track outcomes, and implement targeted interventions for specific groups within the practice.

- Already or mostly established as routine care: This component is already a consistent, standard part of care; the grant would not meaningfully change its use.
- Currently not established and would not likely be established during the grant period: This component is currently not in place and would not likely be established during the grant period due to internal or external constraints.
- Minor impact: This component is not established or is partially established. The grant would provide only minor support to sustain or slightly enhance it.
- Moderate impact: This component is not currently in place or is partially in place. The grant would have a moderate impact on establishing this component as a sustained and routine part of care.
- Significant impact: This component is not currently in place or is partially in place. The grant would have a significant or critical impact on making this component a sustained and routine part of care.

96. For any of the components listed above that were categorized as currently not established and not likely to be established during the grant or minor impact, please explain what would be needed to establish the component:

97. For the SECONDARY service location: Overall, what best describes the SECONDARY service location's current experience with using Medi-Cal dyadic billing codes, in particular CPT code H1011 with modifier U1 for dyadic behavioral health visit? (Select best fit)

- Not familiar with Medi-Cal dyadic billing codes
- Aware of Medi-Cal dyadic billing codes but have not used them
- Have explored or attempted to use Medi-Cal dyadic billing codes

- Use Medi-Cal dyadic billing codes occasionally or inconsistently
- Routinely use Medi-Cal dyadic billing codes but billing is not yet a primary or sustained funding source
- Routinely use Medi-Cal dyadic billing codes and rely on them as a sustained funding source for dyadic services

POPULATION OF FOCUS AND NARRATIVE RESPONSES

The following question set collects information on the service locations' population of focus and rationale for dyadic services through narrative statements. Narrative responses should address the partnership and/or shared strategy between the primary and secondary service location. Any differences in strategies between the two locations should also be stated in the narrative responses, as relevant.

- 98. Describe the target population for dyadic services (age groups, demographics) and the specific gaps and needs that dyadic services are intended to address within this population, including disparities in access and outcomes and how these relate to the identified target population. Include why dyadic services are a good fit for this population and anticipated impacts of dyadic services on patient care and/or practice operations (500 word maximum).**
- 99. Describe the dyadic service components or approaches the service locations aim to prioritize during the grant period and why. (250 word maximum).**
- 100. Describe who will provide dyadic services (e.g., using existing staff, hiring new staff, and the percentage of staff time that will be dedicated to each age group). (200 word maximum)**
- 101. Describe how the grant opportunity would increase or support each service location's dyadic service goals (250 word maximum)**

REQUIRED DOCUMENT UPLOADS

The following section is for document uploads to complete the application.

Name each document upload with the name of the PRIMARY service location followed by the document label. For example, a Leadership letter of Support from Main Street Clinic should be labeled "Main Street Clinic Leadership Letter of Support"

Required uploads include:

- Leadership Letter of Support
- Completed proposed budget for use of grant funds
- Resumes of program lead and other key staff (consolidated into one file for all resumes of key staff)
- Organizational Chart
- Audited Financial Statement
- W-9 Form
- Certificate of Insurance
- Federally Approved Indirect Rate Cost Letter, if applicable

102. File upload: Letter of Support representative of executive leadership from both service locations (Practice Director, CEO, or other relevant entity that has authority to institute change and allocate resources). The Leadership Letter of Support should include:

- Description of each leader's level and role within their organization/practice
- Each leader's commitment to the initiative, including any specific actions already taken
- How they plan to support dyadic care implementation and sustainability (e.g., resource allocation, percent of protected staff time that will be allocated for administration activities)

103. File Upload: Curriculum vitae or resumes of program lead and other key staff (upload one consolidated file with all resumes).

104. File Upload: Proposed Budget for use of grant funds.

105. File Upload: Organizational Chart PRIMARY service location.

- 106. File Upload: Organizational Chart SECONDARY service location.**
- 107. File Upload: Audited Financial Statement PRIMARY service location.**
- 108. File Upload: Audited Financial Statement SECONDARY service location.**
- 109. File Upload: W-9 Form PRIMARY service location.**
- 110. File Upload: W-9 Form SECONDARY service location.**
- 111. File Upload: Certificate of Insurance PRIMARY service location.**
- 112. File Upload: Certificate of Insurance SECONDARY service location.**
- 113. File Upload: Federally Approved Indirect Rate Cost Letter PRIMARY service location, if applicable.**
- 114. File Upload: Federally Approved Indirect Rate Cost Letter SECONDARY service location, if applicable.**
- 115. By submitting this application, I agree that the information provided in this application is true and accurate to the best of my knowledge.**
- Agree and submit
 - Do not agree and withdraw

**IF YOU HAVE QUESTIONS RELATED TO THESE
QUESTIONS, PLEASE EMAIL
SCALINGDYADIC@CIBHS.ORG**