**EXHIBIT A**

**“SAMPLE” SCOPE OF WORK**

**NOTE:** All SOW’s shall have these main headings at a minimum with detailed descriptions. All SOW’s **shall be written by the Department** requesting the services, **NOT** by the Consultant/Professional/Vendor. If one of the sections below is not applicable, then state it in the SOW.

**Introduction:** *What is this Agreement trying to accomplish?*

**Definitions:** *List your definitions here if you are going to be using acronyms throughout the document or if you need to explain the terminology.*

1. **Services Provided:** (detail description)

1. **Term:** *(keep in mind our Fiscal Year is from July 1 through June 30)*
2. **Pricing:** *(****No Lump Sum Pricing****, this needs to be broken down, by the hour, or by the student, or by the class, or by the day, or by the week, per consultant, etc)*
3. **Consultant/Professional Responsibilities:**
4. **District Responsibilities:**
5. **Referral Process***: (if applicable)*
6. **Schedule** **of Events/Milestones:** *(How do you know that the Consultant/Professional is meeting the goals and outcomes of the services being provided to your school or department? What events, milestones or markers do they need to meet?)*
7. **Evaluative Criteria:** *(How will you evaluate the Consultant/Professional services to ensure that the services provided met the goals of the program for the school or Department?)*

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**SAMPLE**

**SCOPE OF WORK**

**Introduction:**

McAlister Institute (“Consultant/Professional”) will provide San Diego Unified School District (“District”) with substance abuse counselors to provide education, and drug testing is available upon parent/guardian request.

Consultant/Professional provides specific methodologies and systems to work with school districts to identify and serve students. The services offered to District include education for students who are using substances and vaping, have been suspended, or are under school disciplinary action related to substance use-related issues.

Consultant/Professional will provide services at District middle and high school sites as agreed by the school site principals.

**Definitions:**

Substance Use Group:

This is defined as an education-based proactive intervention program for high school-aged students who may be under school disciplinary action resulting from substance use-related issues. Groups sessions may be offered as an alternative to disciplinary action or as a self/parent/guardian referral.

Vaping Class Session:

This is defined as an education-based proactive intervention program for middle and high school-aged students

who may be under school disciplinary action resulting from vaping-related issues. Class sessions may be offered as an alternative to disciplinary action or as a self, parent/guardian referral.

Telehealth Platform:

This is defined as the mode of delivering mental health services by using two-way audio and visual communication technology.

1. **Services Provided**

Consultant/Professional will provide the following services on District school sites and/or via virtual teleconferencing platforms as follows:

1. Substance Use Education Groups Sessions
2. Group sessions may be held for one (1) hour per group
3. Group sessions may be held twice per week

1) A maximum of two additional group sessions per week, provided using a telehealth platform, may be added as mutually agreeable by District and Consultant/Professional and preapproved by District

1. Students to attend twelve (12) group sessions to complete the course
2. Group sessions are available to high school students
3. Group sessions are available to middle school students, as approved by District administrators, parent/guardians, and Consultants/Professionals.
4. A maximum of fifteen (15) students per group session (for in-person and telehealth services)

1) A maximum of two (2) additional group sessions per week may be added using a telehealth platform should the number of students in need of group sessions exceed fifteen (15) students, as pre-approved by District and mutually agreed by the parties.

1. Groups sessions are curricula based to focus on various aspects of addiction, which includes:

1) Addiction types (chemicals/ alcohol/ aerosols/ prescriptions drugs etc.)

2) Related Life Skills

3) Health Impact(s)

4) Feelings/Emotions

5) Related Peer Pressure

6) Impact on Relationships

7) Skills Building

1. Most students will attend two (2) group sessions per week for three (3) to six (6) months.
2. Vaping Classes Includes:
   1. Two (2) hours per class
   2. Classes may be provided onsite or using a telehealth platform
   3. Classes may be held biweekly (two (2) classes per month)
   4. Students will attend one (1) class
   5. Classes are available to middle school and high school students
   6. The maximum number of students will be determined by District and Consultant/Professional
3. Attachment 1: Comprises the high school sites to receive services during the 2021 – 2022 school year as stated above. Schools may be added or removed during the term of this Agreement.
4. **Term:**

The term of this Agreement is July 1, 2021 through June 30, 2023. Services will not be offered during school breaks, i.e., Thanksgiving, Spring Break, the two (2) weeks during the Winter Break, and during the four (4) weeks in August.

1. **Pricing:**
   1. Services will be provided online through teleconferencing or onsite if District reopens school sites as approved by District’s Nursing and Wellness Dept.
   2. Price for Onsite Services and Substance Use Groups:

i. Annual cost per school site cluster: $1,556.00 per month, x 11 sessions, for nine (9) months = $154,044.00 per year.

* 1. Teleconferencing Services and Substance Use Groups:
     1. Price per student: $100 x 15 students maximum per class

4 classes maximum per week

Not-to-exceed 36 weeks = $216,000.00

* 1. Vaping Use Classes:

i. Price per school site: $389.00 per class x 2 classes per month, for nine months for a total of 18 classes per year for a maximum amount: $7,002.00 per year.

**4. Consultant/Professional Responsibilities:**

1. Consultant/Professional will be onsite services two (2) times per week for up to two (2) hours per group session at each approved school site, in accordance with and approved by District’s Nursing and Wellness Dept.
   * 1. Consultant/Professional may provide group sessions using a virtual teleconferencing platform.

1) Consultant/Professional may provide weekly classes using a virtual teleconferencing platform.

b. The school site group session schedule will be mutually established between Consultant/Professional and District.

c. All Consultant/Professional staff shall be Registered/Certified Alcohol and Drug Counselors or licensed/licensed eligible mental health clinicians. All counselors shall be trained to provide substance abuse education services per State of California requirements.

d. Consultant/Professional shall have a sign-in sheet for each group or class session, which will serve to document the participant’s group/class service attendance.

i. Sign-in sheets will be provided by Consultant/Professional to the school site administrator weekly.

1. Consultant/Professional shall only initiate services upon receipt of a signed student Consent Form.

i. See Attachment 3 - Consent Form.

1. Consultant/Professional shall provide, at a minimum, monthly updates to the school site administrator regarding the status/outcomes of prevention services. Communication will be provided in person, by phone, or by email.
2. Consultant/Professional shall be responsible for complying with any federal, state, and county regulations in addition to the guidelines for Registered/Certified Alcohol and Drug Counselors, and for all licensed/licensed eligible mental health clinicians, per the California Board of Behavioral Sciences.
3. Consultant/Professional shall be responsible to ensure that its virtual telehealth/ telecommunications platform is Health Insurance Portability and Accountability Act (HIPAA) compliant.
4. Consultant/Professional shall provide supervision to its Licensed Eligible Clinicians Associates:

i. Associate Clinicians (Associate Clinical Social Workers (ACSW), Associate Marriage and Family Therapists (AMFT), Associate Professional Clinical Counselor (APCC).

ii. Consultant/Professional shall provide supervision to its staff per Board of Behavioral Sciences supervision guidelines to ensure the quality of services and clinical oversight.

1. Consultant/Professional shall provide supervision to its Registered/Certified Alcohol and Drug Counselors to ensure the quality of service and clinical oversight.
2. **District Responsibilities:**
   1. District’s school site administrator will provide a confidential location to provide education group sessions.
   2. District’s school site administrator will ensure the school staff, students, and parents are informed of available services.
3. District’s school site administrator, counselor, or designee will provide the required consent forms when referring students to these prevention services.
4. The District’s Mental Health Resource Center Program Manager or designee will serve as the liaison and subject matter resource between its school site administrators and Consultant/Professional.
5. **Referral Process**
   1. District’s school site administrator, counselor, or designee will ensure students and parents are informed of available services and initiate referrals.
   2. District’s school site administrator, counselor, or designee will obtain and provide the following to Consultant/Professional when initiating referrals:
      1. Completed Referral Form; See Attachment 2
      2. Signed Consent Form; See Attachment 3
      3. Signed Consent to Release Confidential Information form; See Attachment 4
6. District’s school site administrator, counselor, or designee will provide a copy of the Consent Form to the Consultant/Professional.
   * 1. The District’s school site administrator, counselor or designee, and Consultant/Professional will begin the student prevention program by establishing a date/time.
7. **Schedule of Events/Milestones:**

Not Applicable to this SOW.

1. **Evaluative Criteria:**

Not Applicable to this SOW.

**ATTACHMENT 1**

**List of School Site Clusters for the Group Session Schedule and Virtual Teleconferencing**

Group schedules may be adjusted and/or changed due to accommodations for school schedules (i.e., high school late start schedules, etc.). District School Site Administrators and Consultant/Professional shall mutually agree to group schedules or adjustments thereof.

School sites may be added or removed during the term of this Agreement.

* Crawford/Patrick Henry

Days/Times to be Determined

* Hoover/ Morse

Days/Times to be Determined

* UCHS/ La Jolla

Days/Times to be Determined

* Madison/ Canyon Hills (formerly Serra)

Days/Times to be Determined

* Clairemont/ Mt. Everest

Days/Times to be Determined

* Scripps Ranch/ Mira Mesa

Days/Times to be Determined

* Mission Bay/ Point Loma

Days/Times to be Determined

* iHigh/ Kearny/ Mark Twain/ SDMET

Days/Times to be Determined

* SDHS/ East Village/ Garfield

Days/Times to be Determined

* Lincoln

Days/Times to be Determined

* School of Creative and Performing Arts (SCPA)

**ATTACHMENT 2**

**MCALISTER INSTITUTE**

**Prevention & Intervention Groups**

**REFERRAL FORM**

**Referring Party Information:**

Date Referred: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Title/Name of Referring Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Student Information:**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Required Referral Documents:**

* Referral Form
* Consent Form

Date Emailed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**McAlister Institute:**

Referral Received By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Health Resource Center

2351 Cardinal Ln. Annex B San Diego, CA 92154

Office: (858)573-2227

Fax: (858)496-2213

Email: ysakamoto@sandi.net

**ATTACHMENT 3**

**MCALISTER INSTITUTE PREVENTION/INTERVENTION GROUPs**

**CONSENT FORM**

**PARENT CONSENT:**

I give consent for\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to participate in educational prevention and intervention services offered by McAlister Institute. I give permission for my student to participate in group’s from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Services offered by McAlister will be held at student’s school of attendance. Services include curricula-based groups focused on the following topics:

* Substance use/abuse
* Related life skills
* Health impact(s)
* Feeling/emotions
* Related peer pressure
* Impact on relationships

I understand that confidentiality related to the group process will be maintained. However, there are, by law, exceptions to confidentiality, including mandatory report of child, elder, and dependent adult abuse and any threats of violence/harm to self or others.

My signature indicates my knowledge and consent for my student to participate in the following (check one or both):

⃞ Prevention/Intervention Groups

⃞ Drug Testing

I also understand that I can revoke this Consent at any time by submitting my request in writing to school site administrator or school counselor.

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STUDENT CONSENT:**

I agree to participate in educational groups offered on campus by McAlister Institute. I understand that confidentiality will be expected and part of the guidelines for group participation. What other students share in the group cannot be discussed with anyone outside of the group. In addition, I am fully aware and agree that all information that I share will not be shared with anyone unless confidentiality needs to be broken to protect me and/or comply with the law.

Confidentiality will be broken if I report that I am in danger (i.e., of hurting myself or another person or if another person in the past or present has been harming me). If this occurs, the counselor facilitating the group will follow reporting procedures as required by law.

Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Health Resource Center

2351 Cardinal Ln. Annex B San Diego, CA 92154

Office: (858)573-2227

Fax: (858) 496-2213

Email: [ysakamoto@sandi.net](mailto:ysakamoto@sandi.net)

**ATTACHMENT 4**

**AUTHORIZATION FOR THE RELEASE OF INFORMATION**

I, , hereby authorize the exchange/disclosure of information regarding my child/family\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ between the San Diego Unified School District School Site Administrator/School Counselor and the following:

McAlister Institute \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Agency Contact Person Telephone Email

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Address State Zip Code

The information to be used and /or released includes: **(please check all that apply)**:

Mental Health/Evaluation/Diagnosis  Psychological Evaluation/Testing

School Records  Family/Psychosocial History

Program Participation Status  Legal/Probation Records/Criminal History

Drug Testing Results  Referrals to Community or Primary Care Agencies

This release authorizes a free exchange of information between SDUSD School Site Administrator or Counselor and the agency or individual above in order to provide the appropriate level of service. It does not authorize release to any other person or agency except those agencies listed above. However, there are by law, exceptions including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing to: MHRC, 2351 Cardinal Lane, Annex B, San Diego, CA 92123 before the information has been released; and that the consent will automatically expire one year (1 year) after the date signed.

Photocopy or Fax: I understand that the revocation will not apply to information that has already been released based upon this authorization. I agree that a photocopy or fax of this authorization is to be considered as effective as the original.

FERPA: I understand that the requestor (School District) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) as the information may become a part of the student’s educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings, school services, and programs.

Redisclosure: If I have authorized disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my health information from redisclosing such information except with my written authorization or as specifically required or permitted by law.

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitting diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about mental health services or treatment for alcohol and drug abuse.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section 164.524.

Signature of parent or authorized representative Please Print Name Date

Signature of youth (if over 12 years of age) Please Print Name Date

Youth’s date of birth: \_\_\_\_\_\_\_\_