New York State

Office of Alcoholism and Substance Abuse Services (OASAS)
Office of Mental Health (OMH)
Office of Mental Retardation and Developmental Disabilities (OMRDD)

Consolidated Budget Reporting and Claiming Manual

For the Periods:

January 1, 2009 to December 31, 2009
July 1, 2009 to June 30, 2010

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Introduction

The Consolidated Fiscal Reporting System (CFRS) is a single, standardized fiscal reporting system used by all organizations receiving funding from the following New York State (NYS) Agencies:

- The NYS Office of Alcoholism and Substance Abuse Services (OASAS),
- The NYS Office of Mental Health (OMH),
- The NYS Office of Mental Retardation and Developmental Disabilities (OMRDD) and
- The State Education Department (SED).

The CFRS is also used by Local Governmental Units (LGUs) that operate and/or fund mental hygiene services.

Funding may be provided through prices, rates, fees and/or Aid to Localities (State Aid). This manual will focus on the State Aid budgeting and claiming aspects of the CFRS. Cost reporting policies and procedures are not included in this manual and can be found in the Consolidated Fiscal Reporting and Claiming Manual.

Throughout this manual OASAS, OMH and OMRDD will be referred to as the DMH State Agencies unless specifically identified.

The CFRS consists of the following components and associated documents and forms:

CFRS Component	Document Name	Document Acronym
Budgeting	Consolidated Budget Report	CBR
Intra-Year Claiming (Mid-Year, Quarterly, Monthly, etc.)	Agency Quarterly Fiscal Summary NYC Quarterly Fiscal Summary (NYC Department of Health & Mental Hygiene only) LGU Fiscal Summary (Non-NYC LGUs only)	CQR-1 CQR-2 CQR-3
Year-End Cost Report (Includes Consolidated Claim Report listed below)	Consolidated Fiscal Report	CFR
Year-End Claiming	Consolidated Claim Report NYC Quarterly Fiscal Summary (NYC Department of Health & Mental Hygiene only) LGU Fiscal Summary (Non-NYC LGUs only)	CCR CQR-2 CQR-3

The information contained in this manual documents and explains procedures and

step-by-step instructions for fulfilling fiscal reporting requirements related to the receipt of State Aid in the CFRS.

Contacts

If any further explanation is needed, the following persons may be contacted:

For Budgeting:

Bureau of Budget Management (518) 485-2193
Office of Alcoholism and Substance Abuse Services
1450 Western Avenue
Albany, New York 12203-3526

Community Budget and Financial Management (518) 486-9831
Office of Mental Health
44 Holland Avenue
Albany, New York 12229

Mr. John Smith (518) 474-8962
Office of Mental Retardation and Developmental Disabilities
44 Holland Avenue
Albany, New York 12229

For Claiming:

Bureau of Financial Management (518) 457-3562
Office of Alcoholism and Substance Abuse Services
1450 Western Avenue
Albany, New York 12203-3526

Bureau of Contract and Claims (518) 473-7885
Office of Mental Health
44 Holland Avenue
Albany, New York 12229

Bureau of Community Funding (518) 402-4248
Office of Mental Retardation and Developmental Disabilities
44 Holland Avenue – 3rd Floor
Albany, New York 12229

Resources

Manuals

Consolidated Budget Reporting and Claiming Manual (CBR Manual)
Consolidated Fiscal Reporting and Claiming Manual (CFR Manual)

Forms

Consolidated Budget Report (CBR)
Consolidated Quarterly Reports (CQR-1, CQR-2 and CQR-3)
Consolidated Fiscal Report

CFR Extension Requests

New York State CFR Software

Interagency New York State Software
Phone: 1-800-HELPNYS (1-800-435-7697)

Interagency CFRS Training

In order for the DMH State Agencies to adequately process the Consolidated Budget Report (CBR), intra-year claims (CQRs), and Consolidated Claiming Report (CCR), standardized procedures must be followed in preparing the applicable reports.

General Instructions

1. In accordance with the instructions contained in this manual, CBRs, CQRs and CCRs must be completed including schedules for each DMH State Agency providing Aid to Localities (State Aid) funding to the service provider. Aid to Localities funding may be provided directly to the service provider through a contract with the funding DMH State Agency(ies) or through a contract with the Local Governmental Unit (LGU) by means of the County Approval Letter process.

2. The same array of programs reported on an approved CBR must also be included on the CQR, CCR and CFR, and for Article 28 Hospitals, the Institutional Cost Report (ICR). If a provider reports a program discretely on an approved CBR, that program must also be reported discretely on all other fiscal documents submitted to the DMH State Agency and the Department of Health. For example, providers may not report a case management program's expenses and revenues as a discrete program on one document, but include those same revenue and expenses as part of a clinic treatment program on a different document. Programs should only be reported discretely if they are operated as individual programs and are not part of a larger program.

3. Service providers receiving funding from more than one County LGU must complete separate CBRs, CQRs and the DMH-2, DMH-2A (not required by OMH) and DMH-3 schedules in the CCR for each county. Costs will be distributed between each county based on units of service or percentages approved by the funding DMH State Agency(ies).

4. A DMH State Agency's portion of a shared program is reported on the *same* CBR, CQR and CCR schedules as with programs funded solely by that DMH State Agency. An example of a shared program is LGU Administration (program code 0890). Additionally, fiscal information for shared programs must be submitted to each State agency associated with the funding of that shared program.

5. Section 41.47(k) of the Mental Hygiene law specifies that any county that receives Community Support Services (CSS) funding and which has a population of less than 100,000 or which has total program expenditures for mentally ill persons equal to or less than $500,000 in a local fiscal year shall be permitted flexibility in regard to the commingling of funds. Any county that meets at least one of these two criteria, and has OMH programs funded through both CSS and LA, does not have to treat each funding source as a separate program.)

6. For LGU operated service providers, the accounting entity is determined by the New York State Office of the State Comptroller according to categories contained in the Unified System of Accounts for Counties (USAC).

7. It is the responsibility of LGUs to ensure that local contract funded service providers:

   i. have the appropriate fiscal record keeping expertise to record and report expenditures and revenues in accordance with the instructions, policies and practices contained in this manual and related resources, and

   ii. fiscal reporting is accomplished in a consistent and timely manner.

Documents completed that do not comply with instructions, policies and practices contained in this manual will not be accepted. Each DMH State Agency reserves the right to impose sanctions or penalties as a result of improperly completed or delinquent CBRs, CQRs and/or CCRs.

OMH-Specific General Instructions

1. All service providers receiving net deficit funding from OMH for any program must include *all* certified and non-certified mental health programs, except for non-funded inpatient programs, on all CBRs, CQRs CFRs and CCRs. This requirement also includes those programs certified by OMH and funded entirely by Medicaid. OMH will not approve a CBR that does not include all licensed/certified mental health programs.

2. The Office of Mental Health is changing the way it requires providers to report subcontract arrangements beginning with the 07/01/07-06/30/08 reporting period. The requirements are being revised to better reflect the costs of providing the needed services by eliminating double reporting. This will also allow providers to report in a way which will match the inventory of programs as specified in MHPD.

   Providers who receive funding via a direct contract with OMH, or through an approval letter with the County, will now be expected to report the program type being contracted for on all reporting documents, regardless of whether they subcontract the actual provision of services to another provider.

   - For example, if Provider A has a contract with Madison County to operate an Advocacy/Support program, Provider A would need to show a column for this program (1760) on their CBR and their CFR schedules. If Provider A subcontracts the operation of the program to Provider B, Provider A still needs to report the program as if they were operating it themselves.

   Generally, all expenses paid to the subcontractor will be shown as an OTPS cost. The funding source codes used will be the ones used on the CBR, and will be appropriate for the program type code used. Funding source codes 065-068 will no longer be used.

   Provider B (the subcontractor) will not be required to segregate the expenses and revenues related to this subcontract separately for reporting to OMH. Provider B does not need to report the subcontract as an OMH program on their CBR or CFR. Provider B should include the expenses and revenues related to the operation of this program

on their CFR on Schedule CFR-2 as 'Other Programs'. Provider A can request cost information from Provider B if they wish, but should not require the data be entered on a CBR or CFR to support this request.

3. When preparing a CBR for OMH, providers must refer to the OMH Resources web site for specific information on the Aid to Localities Spending Plan Guidelines.

OMRDD-Specific General Instructions

1. CBRs, CQRs and CCRs must show the expenses and revenues of the entire incorporated organization's funded and non-funded mental retardation services except for Medicaid and HCBS Waiver funded programs.

Miscellaneous Instructions and Information

1. The schedules of the CBR, CQR and CCR detail the following information:

Agency Name & Address	The incorporated name, street and city address of the service provider operating the program site(s).
Agency Code	The agency code number is the five (5) digit number listed on the mailing label of the letter notifying you that a new version of the CBR Manual is available for download.
Program Code	See Appendices E-G for each DMH State Agency's valid program codes. Example: 7070 – Treatment/Apartment.
Program/Site Identification Number	PRU Number, Facility-Unit Code, or Operating Certificate Identification Number
Contract Number	The DMH State Agency contract number or the number of the local county contract with the funding LGU. Note: If the funding LGU does not use contract numbers, enter the first seven (7) letters of the county name as a proxy. If the county name is seven (7) letters or less, enter the complete county name.

2. Each set of CBR, CQR and CCR schedules must be returned with the appropriate State Agency(ies) identification information completed.

3. Each set of CBR, CQR and CCR schedules must be numbered consecutively starting with the first page of the document and ending with the last page of the document. Schedules comprised of more than one page must be kept together as a set.

Example: A set of schedule DMH-2 would consist of DMH-2.1 and DMH-2.2 in order for each DMH State Agency and/or county.

4. Do not use dollar signs. Round all cents to the nearest whole dollar.

   Example: 47.50 = 47 or 35.51 = 36.

5. FTE's should be rounded to three decimal places

   Example: 4.53467 = 4.535

6. The DMH State Agencies' policies and procedures regarding the reporting of In-Contact versus Out-of-Contract programs can be found in Appendix Z of this manual and the Consolidated Fiscal Reporting and Claiming Manual (CFR Manual). A definition of In-Contract/Out-of Contract can also be found in the Glossary (Appendix A) of this manual and the CFR Manual.

7. Direct contract funded service providers should review Appendix W for an explanation of New York State Prompt Contracting policies.

The DMH State Agencies recognize three (3) methods of accounting service providers and Local Government Units (LGUs) can use to maintain fiscal records and provide the required reports.

The three methods of accounting recognized by the DMH State Agencies are:

- *Accrual Accounting*

  Accrual accounting records revenues when earned or when levies are made and records expenditures as soon as they result in liabilities for benefits received, notwithstanding that the receipt of the revenue or the payment of the expenditure will take place, in whole or in part, in another accounting period.

  Accrual accounting is the preferred method of accounting for non-governmental service provider agencies.

- *Modified Accrual Accounting*

  Modified accrual accounting treats revenues and expenditures as follows:

  Revenues are recorded when received except:

  - Those revenues which are susceptible to accrual. Revenues are susceptible to accrual if they are measurable and available to finance the operations of the current year. "Available" means collectible within the current accounting period or soon enough thereafter to be used to pay liabilities of the current period. Generally, such time "thereafter" should not exceed 60 days.

  - Those revenues of a material amount that have not been received at the normal time of receipt. Revenues of a material amount ordinarily recorded on a cash basis will be accrued if receipt is delayed beyond the normal time of receipt.

  Expenditures are recorded when incurred. Compensation due to employees and related fringe benefits at the end of the year will be accrued. Personal services expenses must be reasonable and necessary for providing services and fringe benefit expenses are an allowable expense to the extent they are reasonable and available to all employees. Liabilities for retirement costs of public retirement systems will be recorded as an expenditure when due to that retirement system.

  County governments are required to use modified accrual accounting by the Office of the State Comptroller.

- *Cash Accounting*

  Cash accounting records revenues when received and records expenditures when paid.

  Although cash accounting is recognized for use by DMH State Agency funded service providers, caution is advised in its use as it may provide a distorted view of the service provider's fiscal activity and does not provide comparable fiscal reports from period to period.

General Instructions

1. CBRs, CQRs and CCRs may be completed using one of the three recognized methods of accounting described above.

2. Service providers and LGUs must use the same method of accounting for all CBR, CQR and CCR submissions within the same fiscal reporting period. Service providers and LGUs must also use the same method of accounting for all CBR, CQR and CCR submissions from year to year.

3. Service providers cannot change their method of accounting without *prior* approval by the funding DMH State Agency(ies) and, if funded through a local contract, the funding LGU.

4. LGUs cannot change their method of accounting without *prior* approval by the funding DMH State Agency(ies).

Consolidated Fiscal Reporting System (CFRS) software is available from the New York State Office of Mental Health. CFRS software can be used to complete Consolidated Budget Reports (CBRs), intra-year claim reports (CQRs), year-end Consolidated Fiscal Reports (CFRs) and year-end final State Aid claims (CCRs).

CBRs, CQRs, CFRs and CCRs generated by non-approved software will not be accepted and will be returned to the service provider or Local Governmental Unit (LGU).

The NYS Office of Alcoholism and Substance Abuse Services (OASAS), NYS Office of Mental Health (OMH) and NYS Office of Mental Retardation and Developmental Disabilities (OMRDD) expect that all CBRs, CQRs, CFRs and CCRs will be completed using approved CFRS software.

Software makes preparing CFRS documents easier by:

- Reducing data entry.
- Preventing the use of incorrect coding information.
- Ensuring that all mathematical calculations are correct.
- Accurately carrying data from one CFRS document schedule to another.
- Validating and identifying errors prior to CFRS document submission.

Approved software will:

- Perform the edits required by the CFR Interagency Committee.
- Assign a unique Document Control Number (DCN) to the CFR submission each time the final edits are run successfully.
    - A CFR must have a DCN in order to be an acceptable submission.
    - A DCN indicates that final calculations and carry-forwards have been completed.
- Create an upload file in the correct format.

Please Note: OMH CFR Software has a single version to be used for the current reporting period and for all reporting periods back to 2002/2003. That is, if an agency needs to revise a prior period CFR dating back to 2002/2003, they would download the current reporting period OMH CFR software from the OMH CRFS website, and then proceed to import and revise the prior period CFR accordingly.

CFRs generated by approved software must be submitted via the Internet. A DCN is required in order to create the upload file which will be transmitted via the Internet. The State agencies do not currently accept electronic signatures for the certification schedules (CFR-i, CFR-ii or CFR-iiA, and CFR-iii). Therefore, signed paper copies of the certification schedules must be sent to each applicable State agency along with a copy of the service provider's certified financial statements. The DCN on the certification schedules must match the DCN of the Internet submission.

CFRS document facsimiles are not allowed by all three DMH State Agencies.

To obtain information concerning approved CFRS software, contact the DMH State Agency that funds your program(s).

For information regarding the technical operation of New York State software, call 1-800-HELP-NYS (1-800-435-7697).

The approved CFRS software is available from:

NYS Office of Mental Health
Center for Information Technology (CIT)
44 Holland Avenue
Albany, NY 12229
1-800-HELPNYS
(1-800-435-7697)

Each DMH State Agency has different policies, procedures and practices regarding budget modifications.

OASAS Budget Modifications

OASAS does not require submission of revised Consolidated Budget Report (CBR) schedules for budget modifications. To affect changes to county operated and not-for-profit service provider budgets, Program Budget Change Requests (PBCRs) and/or Spending Plan Modifications (SPMs) should be submitted in accordance with established OASAS guidelines and principals.

Blank PBCR and SPM forms can be obtained from OASAS Field Offices.

OMH Budget Modifications

Direct Contract Providers: For budget modifications to programs funded through a direct contract with OMH, contact the appropriate regional field office representative.

Local Contract Providers: For budget modifications to programs funded through the local contract Approval Letter process, please refer to the Aid to Localities Spending Plan Guidelines posted on the OMH Resources web page. Particular attention should be paid to State Aid Approval Letter General Provisions section.

OMRDD Budget Modifications

Direct Contract Providers: For budget modifications to programs funded through a direct contract with OMRDD, contact the local Developmental Disabilities Service Office (DDSO).

Local Contract Providers: For budget modifications to programs funded through the local contract Approval Letter process, contact the funding LGU or the OMRDD Community Funding – State Aid Claims.

Process	***Submission Dates***	
	Counties	*New York City*
Receipt of current year final budgets (OMRDD)	February 15	December 31
Receipt of county operated and service provider budgets for the current fiscal year (OASAS)	October 1 (with work scope)	April 1 (with work scope)
Receipt of County Preliminary Allocation Summary (OMH)	April 1	October 1
Receipt of final budgets (OMH)	November 1	October 1

Note: *OASAS funded service providers should address any questions they may have regarding submission of budget related materials to their OASAS Field Office Program Specialist.*

This section of the manual describes the minimum requirements service providers *must* comply with if they receive Aid to Localities (State Aid) funding from one or more of the DMH State Agencies. These requirements cover fiscal record keeping and the completion and submission of intra-year and year-end fiscal reports under the Consolidated Fiscal Reporting System (CFRS).

Requirements for reporting fiscal information are different for service providers receiving State Aid through a contract with a Local Governmental Unit (LGU) and those service providers receiving State Aid through a direct contract with a DMH State Agency.

Fiscal Record Keeping Requirements

The policies of the DMH State Agencies regarding service provider accountability and fiscal record keeping are indicated below. These policies apply to *all* county operated service providers, *all* local contract funded not-for-profit service providers and *all* direct contract funded not-for-profit service providers receiving State Aid from a DMH State Agency.

1. Service providers are required to account for expenditures and revenues by program category as budgeted and approved by the funding DMH State Agency(ies).

2. Journals and ledgers must comply with generally accepted accounting standards and should be maintained as prescribed by the funding DMH State Agency(ies).

3. Service providers must maintain all documentation supporting the fiscal data reported in accordance with generally accepted accounting standards.

4. DMH State Agency standards and requirements are the minimum standards and requirements required of funded service providers. LGUs may establish additional documentation and/or submission requirements consistent with LGU practices.

5. Service providers must maintain records and supporting documentation for a period of six (6) years after the date of the last State Aid payment made by the funding DMH State Agency(ies). These records and supporting documentation must be made available at all times, without prior notice, for audit and evaluation by representatives of the funding DMH State Agency(ies) and/or the Office of the State Comptroller (OSC) and/or the Federal Government.

6. Service providers will require subcontract agencies to make available to the DMH State Agency, OSC and/or the Federal Government during regular business hours all financial data related to the services provided under the contract.

General Fiscal Reporting Requirements

1. County operated service providers *must* allocate agency administration expenses to the DMH State Agencies using the ratio value methodology. After allocating each funding DMH State Agency its ratio value share of agency administration, county operated service providers must allocate each DMH State Agency's share between that State Agency's programs using the same methodology utilized in the approved operating budget for the fiscal reporting period.

2. County operated and not-for-profit service providers *must* indicate the method of accounting used on the appropriate intra-year and final State Aid claim documents. Service providers cannot change their method of accounting without specific prior approval from the funding DMH State Agency(ies) and, if funded through a local contract, the LGU.

3. At a minimum, county operated and not-for-profit service providers are required to submit fiscal reports to the LGU or, in the case of direct contracts, to the funding DMH State Agency in accordance with established time frames. At their discretion, LGUs may implement more frequent reporting requirements consistent with existing LGU practices in such matters.

4. *Reimbursable* expenditures reported *must* be within the amounts established in the county operated or not-for-profit service provider's approved budget and contract (if applicable). Reimbursable expenditures are also subject to limits established by the funding DMH State Agency(ies).

5. County operated and not-for-profit service providers encountering changes in program operations that significantly alter the original budget must modify that budget to better reflect the fiscal activity of the service provider under the changed conditions. (For County operated and not-for-profit service providers funded by OASAS, prior approval of changes in program operations or approved budgets is required.)These budgetary changes should be submitted no later than April 30 (August 15 for New York City) of the following fiscal year. This is particularly critical for LGU administration budgets and in shared programs where shifts in actual service delivery may affect the distribution of funding among/between DMH State Agencies. Please see Section 5 for more information on the modification of service provider approved budgets.

6. Allowable costs under all State Aid funding arrangements with DMH State Agencies *must* meet *all* of the following criteria:

    i. necessary and reasonable for proper and effective program operations;
    ii. specifically provided for in the approved budget;
    iii. not prohibited by Federal, State or Local laws, regulations and/or policies;
    iv. not allocable or included as a cost of any other program in a prior, current, or subsequent fiscal period; and
    v. not specifically prohibited in Appendix X of this manual and the Consolidated Fiscal Reporting and Claiming Manual (CFR Manual).

Intra-Year Fiscal Reporting Requirements ***(OASAS And OMRDD Only)***

Note: *OMH does not require the submission of intra-year claims.*

However, LGUs may, at their discretion, require intra-year claims from county operated and not-for-profit service providers funded through the OMH Approval Letter process. Service providers funded through the OMH Approval Letter process should contact the appropriate LGU(s) for their specific intra-year reporting requirements.

Intra-year fiscal reporting requirements for OASAS and OMRDD funded county operated and not-for-profit service providers are as follows:

1. County operated and not-for-profit service providers will use the Agency Quarterly Fiscal Summary (CQR-1) to report intra-year fiscal activity as follows:

   OASAS: OASAS expects all service providers to use approved CFRS Software to complete Intra-Year Fiscal Reporting documents and to submit those documents via the Internet. At this time, paper copies are still required to be sent directly to OASAS' Bureau of Financial Management.

   Direct Contracts: At a minimum, county operated and not-for profit service providers funded through a direct contract with OASAS will submit a mid-year (6 month) intra-year claim covering the first two quarters of the fiscal reporting period. At its discretion, OASAS reserves the right to require more frequent intra-year claim submissions from funded service providers (i.e. quarterly, monthly, etc.).

   LGUs: At a minimum, county operated and not-for profit service providers funded through a local contract with an LGU will submit a mid-year (6 month) intra-year claim covering the first two quarters of the fiscal reporting period. At its discretion, OASAS reserves the right to require more frequent intra-year claim submissions from funded service providers (i.e. quarterly, monthly, etc.).

   OMRDD: Direct Contracts: Direct contract funded service providers should also refer to Appendix C (Payment Schedule) of their fully executed contract with OMRDD. At its discretion, OMRDD reserves the right to require more frequent intra-year claim submissions from funded service providers (i.e. monthly, etc.).

LGUs: At a minimum, county operated and not-for profit service providers funded through a local contract with an LGU will submit a mid-year (6 month) intra-year claim covering the first two quarters of the fiscal reporting period. At its discretion, OMRDD reserves the right to require more frequent intra-year claim submissions from funded service providers (i.e. quarterly, monthly, etc.).

Note: *Service providers funded through a local contract with an LGU are directed to check with the funding LGU for LGU-specific requirements on fiscal reporting.*

2. County operated and not-for-profit service providers will prepare CQR-1s in accordance with the instructions provided in this manual.

3. County operated and not-for-profit Article 28 hospitals that are approved by the funding DMH State Agency(ies) to use the "Medicaid Option" will report actual intra-year expenditures and revenues consistent with the "Medicaid Option" procedures described in Appendix Y of this manual and the CFR Manual.

4. County operated and not-for-profit service providers will prepare CQR-1s within the time frames established by the funding DMH State Agency(ies) and/or LGU for receipt by the funding DMH State Agency as follows:

   OASAS: Direct Contracts: The mid-year claim for direct contracts is due for receipt by OASAS no more than 45 days after the end of the first six months of the fiscal reporting period.

   LGUs: The mid-year claim for LGUs is due for receipt by OASAS no more than 45 days after the end of the first six months of the fiscal reporting period.

   OMH: OMH funded service providers are not required to submit intra-year claims.

   OMRDD: Direct Contracts: Direct contract funded service providers should refer to Appendix C (Payment Schedule) of their fully executed contract with OMRDD.

   LGUs: The mid-year claim for LGUs is due for receipt by OMRDD no more than 45 days after the end of the fiscal reporting period.

5. County operated and not-for-profit service providers will prepare revised CQR-1s for expenditures and revenues incurred during the fiscal reporting period that were not

included on the original CQR-1 submitted for that period or to correct errors on the original CQR-1 submitted. Revised CQR-1s should be completed consistent with the service provider's approved method of accounting and reporting.

6. Cumulative fiscal data should take into account any adjustments made to the county operated or not-for-profit service provider's CQR-1 as a result of LGU and/or OASAS or OMRDD review and approval.

7. County operated service providers *must* allocate agency administration expenses to programs other than LGU administration (program code 0890). LGU administration is considered a unique cost center separate and distinct from agency administration expenses incurred by other county operated programs. Agency administration expenses for the management and oversight of all county operated programs other than program code 0890 *cannot* be included in the expenses reported under program code 0890. Please see Appendix I and Appendix K of this manual and the CFR Manual for more detailed information on agency administration and LGU administration.

8. County operated and not-for-profit service providers *must* report and distribute agency administration expenses using the same methodology utilized in their approved budget.

9. County operated and not-for-profit service providers with programs serving more than one LGU and/or DMH State Agency *must* take the total expenditures for the program(s) and distribute them between the affected LGUs' and/or State Agency's(ies') CQR-1s based on the relative units of service provided for each LGU and/or DMH State Agency.

   The approved methodology for distributing these expenditures is as follows:

   Methodology

   a. First, determine the following information from the aggregate statistical information for the fiscal reporting period:

      i. The cumulative total units of service for *all* funding DMH State Agencies.
      ii. The total OASAS-specific units of service.
      iii. The total OMH CSS units of service.
      iv. The total OMH Local Assistance units of service.
      v. The total OMRDD Chapter 620 units of service.
      vi. The total OMRDD non-Chapter 620 units of service.

   b. Second, determine the cumulative total program expenditures for the fiscal reporting period for all funding DMH State Agencies.

   c. Third, divide the total cumulative expenditures by total cumulative units of service to develop the program's gross cost per unit of service.

Note: *Use Six (6) Decimal Places In Applying The Gross Cost Per Unit Of Services For The Calculations Below.*

d. Fourth, determine the gross expenditures attributable to each funding DMH State Agency's funding source(s) by multiplying the units of service for each funding source by the gross cost per unit of service developed in item 6 c above.

10. *For OMRDD funded programs only:* Service providers must account for and report revenue and net expenditures in accordance with the revenue allocation methodologies used in their approved budgets. There are two (2) accepted revenue allocation methodologies:

    a. "Participant Specific Revenue Allocation Methodology" allocates the amount of revenue attributable to each funding source in a program based on the revenue generated by the participants specific to the program. After entry of the revenue data on the CQR-1 by program and funding source, net expenditures are determined by subtracting applied revenues from total expenses.

    b. "Non-Participant Specific Revenue Allocation Methodology", allocates revenues and net expenditures to each funding source in a program based on the net cost per unit of service developed using the same methodology illustrated in Item 7 above.

    In brief, after determining the net expenditures for the total program, divide the total net program expenditures by the total units of service to derive the net cost per unit of service. Then, multiply the units of service for each funding source by the net cost per unit of service to develop the net cost by funding source. Revenue is determined by subtracting net expenses from gross expenses for each funding source.

    Note: *Use Six (6) Decimal Places In Applying The Net Cost Per Unit Of Services For The Calculations Below.*

11. Total LGU administration expenditures (program code 0890) *must* be allocated to OASAS and OMRDD CQR-1s using the approved 1988 percentages found in Appendix K of this manual and the CFR Manual.

12. County operated and not-for-profit service providers *must* submit their intra-year claims as follows in accordance with the timeframes indicated in Item 4 of this section:

    a. Service providers receiving State Aid solely through a local county contract with an LGU will submit their CQR-1's to the contracting LGU.

    b. Service providers receiving State Aid through both a local county contract with an LGU and a direct contract with OASAS or OMRDD will submit CQR-1s to both the contracting LGU *and* the funding DMH State Agency simultaneously.

c. Service providers receiving State Aid solely through a direct contract with OASAS or OMRDD will submit CQR-1s directly to the funding DMH State Agency.

d. A service provider that provides services for more than one LGU must submit separate CQR-1s for each LGU.

Note: *Service providers funded through a local contract with an LGU or the NYC Department of Health and Mental Hygiene (NYC DOHMH) are directed to check with the funding LGU or NYC DOHMH for their specific requirements on fiscal reporting.*

Final Fiscal Reporting Requirements

1. County operated and not-for-profit service providers will use the State Aid claiming schedules included in the year-end Consolidated Fiscal Report (CFR) as the final claim. These schedules are referred to as the Consolidated Claim Report (CCR) and consist of the CFR-i, CFR-iii, DMH-2, DMH-2A (OASAS and OMRDD Only) and DMH-3 State Aid Claiming schedules included in the complete CFR document.

2. County operated and not-for-profit service providers will prepare CCRs in accordance with the instructions provided in the Consolidated Fiscal Reporting and Claiming Manual (CFR Manual).

3. County operated and not-for-profit service providers *must* prepare CCRs using the same methodologies and principles used to prepare their approved budgets and intra-year State Aid claims.

4. County operated and not-for-profit hospital providers that are approved by the funding DMH State Agency(ies) to use the “Medicaid Option” will report actual year-end expenditures and revenues on the CCR consistent with the “Medicaid Option” procedures described in Appendix Y of this manual and the CFR Manual.

5. County operated and not-for-profit service providers will prepare CCRs within the time frames established by the funding DMH State Agency(ies) and/or LGU for receipt by the funding DMH State Agency(ies) as follows:

OASAS: OASAS expects all service providers to use approved CFRS Software to complete Final Fiscal Reporting documents and to submit those documents via the Internet. At this time, paper copies are still required to be sent directly to OASAS’ Bureau of Financial Management.

Direct Contracts: The CCR for direct contracts is due for receipt by OASAS no more than 120 days after the end of the fiscal reporting period.

LGUs: The CCR for LGUs is due for receipt by OASAS no

		more than 120 days after the end of the fiscal reporting period.
OMH:	Direct Contracts:	The CCR for direct contracts is due for receipt by OMH no more than 120 days after the end of the fiscal reporting period.
	LGUs:	Service providers funded through a local contract with an LGU should refer to the LGU's fiscal reporting requirements and the OMH Aid to Localities Spending Plan Guidelines.
OMRDD:	Direct Contracts:	The CCR for direct contracts is due for receipt by OMRDD no more than 120 days after the end of the fiscal reporting period.
	LGUs:	Service providers funded through a local contract with an LGU should refer to the LGU's fiscal reporting requirements

6. County operated service providers *must* allocate agency administration expenses to programs other than LGU administration (program code 0890). LGU administration is considered a unique cost center separate and distinct from agency administration expenses incurred by other county operated programs. Agency administration expenses for the management and oversight of all county operated programs other than program code 0890 *cannot* be included in the expenses reported under program code 0890. Please see Appendix I and Appendix K of this manual and the CFR Manual for more detailed information on agency administration and LGU administration.

7. County operated and not-for-profit service providers *must* report and distribute agency administration expenses on the CCR using the same methodology utilized in their approved budget.

8. County operated and not-for-profit service providers with programs serving more than one (1) DMH State Agency must account for these expenditures as follows:

CFR Cost Report (Core) Schedules:	On CFR core schedules CFR-1, CFR-4, CFR-4A and DMH-1, programs are reported as sites on individual DMH State Agency schedules or on shared program schedules.
CCR Final Claim Schedules:	On CCR final claim schedules DMH-2, DMH-2A (OASAS and OMRDD only) and DMH-3, programs are reported on DMH State Agency specific, county specific schedules.

Shared program expenses are reported on DMH State Agency specific schedules. Expenses, revenues and net operating costs are distributed between the applicable DMH State Agencies based on the relative units of service provided.

9. County operated and not-for-profit service providers with programs serving more than one (1) county must account for these expenditures as follows:

CFR Cost Report (Core) Schedules:	On CFR core schedules CFR-1, CFR-4, CFR-4A and DMH-1 programs serving and/or operating in more than one (1) county are reported as sites on individual DMH State Agency schedules or shared program schedules.
CCR Final Claim Schedules:	On CCR final claim schedules DMH-2, DMH-2A and DMH-3 individual programs serving and/or operating in more than one (1) county are reported on DMH State Agency specific, county specific schedules. Shared program expenses are reported on DMH State Agency specific, county specific schedules. Expenses, revenues and net operating costs are distributed between the applicable DMH State Agencies and/or counties based on the relative units of service provided.

10. *For OMRDD funded programs only:* Service providers *must* account for and report revenue and net expenditures on the CCR in accordance with the revenue allocation methodologies described in item 9 of Service Provider Intra-Year Fiscal Reporting Requirements.

11. Total LGU administration expenditures (program code 0890) *must* be allocated to each funding DMH State Agency's CCR using the approved 1988 percentages found in Appendix K of this manual and the CFR Manual. Agency administration expenses for county operated programs cannot be included in program code 0890 (see item 6 above).

12. Service providers must submit their CCR final claims as follows in accordance with the timeframes indicated in Item 5 of this section:

    a. Service providers receiving State Aid solely through a local county contract with an LGU will submit their CCRs to the contracting LGU.

b. Service providers receiving State Aid through both a local county contract with an LGU and a direct contract with a DMH State Agency will submit CCRs to both the contracting LGU *and* the funding DMH State Agency simultaneously.

c. Service providers receiving State Aid solely through a direct contract with a DMH State Agency will submit CCRs directly to that DMH State Agency.

d. A service provider that provides services for more than one LGU must submit separate CCRs for each LGU.

Note: *Service providers funded through a local contract with an LGU or the NYC Department of Health and Mental Hygiene (NYC DOHMH) are directed to check with the funding LGU or NYC DOHMH for their specific requirements on fiscal reporting.*

This section of the manual describes the minimum responsibilities and requirements for Local Governmental Units (LGUs) receiving Aid to Localities (State Aid) funding from one or more of the DMH State Agencies. State Aid received by an LGU may be used to partially or fully fund mental hygiene programs run by county operated or local contract funded not-for-profit service providers.

There are four (4) main areas of LGU responsibility:

i. Maintenance of LGU fiscal records,

ii. LGU oversight of county operated and local contract funded not-for-profit service provider fiscal record maintenance.

iii. preparation and submission of LGU fiscal reports, and

iv. LGU oversight of county operated and local contract funded not-for-profit service provider fiscal report preparation and submission.

As stated in the first paragraph of this section, the responsibilities and requirements described in this manual are the minimum requirements mandated by the DMH State Agencies. LGUs may, at their discretion, impose additional or more stringent reporting requirements on county operated and local contract funded not-for-profit service providers as long as those requirements do not conflict with or contradict DMH State Agency requirements

Fiscal Record Keeping Requirements

The policies of the DMH State Agencies regarding accountability and fiscal record keeping for LGUs as well as LGU responsibilities governing the oversight of county operated and local contract funded not-for-profit service providers are indicated below:

1. It is the LGU's responsibility to ensure that all county operated and local contract funded not-for-profit service providers maintain journals and ledgers in compliance with generally accepted accounting standards.

2. It is the LGU's responsibility to ensure that all county operated and local contract funded not-for-profit service providers' accounting systems are adequate for meeting accountability and reporting requirements.

3. It is the LGU's responsibility to ensure that county operated and local contract funded not-for-profit service providers account for expenditures and revenues by program category as budgeted for and approved by the funding DMH State Agency(ies).

4. It is the LGU's responsibility to ensure that fully executed local contracts exist between the LGU and all non-county operated not-for-profit service providers.

5. It is the LGU's responsibility to ensure that fully executed local contracts contain all mandatory State and, if applicable, Federal clauses.

6. It is the LGU's responsibility to ensure that fully executed local contracts are provided to the DMH State Agencies as follows:

   OASAS: OASAS does not require copies of local contracts.

   OMH: OMH does not require copies of local contracts.

   OMRDD: Send one (1) copy of all local contracts and budgets to the Bureau of Community Funding in Albany.

7. It is the LGU's responsibility to ensure that all county operated and local contract funded not-for-profit service providers maintain fiscal records and supporting documentation for a period of six (6) years after the date of the last State Aid payment made by the funding DMH State Agency. The LGU will ensure that these records and supporting documentation can be made available at all times, without prior notice, to representatives of the funding DMH State Agency(ies), the Office of the State Comptroller, the Federal Government and/or any other oversight agency or controlling party.

LGU General Fiscal Reporting Requirements

In the Consolidated Fiscal Reporting System (CFRS) LGUs have a wide range of responsibilities regarding the management and oversight of locally funded service providers. The DMH State Agencies will hold LGUs accountable to the requirements that follow. Please note that the standards presented here are minimum standards. The DMH State Agencies may, at their discretion, impose additional requirements and standards.

The general LGU fiscal reporting requirements and associated responsibilities that follow apply to the mid-year *and* final year-end claim schedules for the LGU itself, funded county operated service providers and local contract funded not-for-profit service providers. LGUs are required to thoroughly review these claim schedules for compliance with these standards and any other expressed standards for the fiscal reporting period *prior* to their submission to the funding DMH State Agencies.

OMH Note: *OMH does not require the submission of mid-year claims.*

1. It is the LGU's responsibility to ensure that claim schedules are prepared and submitted by county operated and local contract funded not-for-profit service providers in a timely manner. LGUs are expected to establish submission dates that will allow for proper LGU review of these materials prior to their submission to the funding DMH State Agency(ies) by the prescribed due dates.

2. It is the LGU's responsibility to submit the required claim schedules for all local funded service providers to the applicable DMH State Agency(ies) by the prescribed submission due dates.

3. It is the LGU's responsibility to ensure that expenditures and revenues are reported properly and in accordance with specific funding DMH State Agency requirements.

4. It is the LGU's responsibility to ensure that the expenses reported are necessary and reasonable for proper and effective program operation.

5. It is the LGU's responsibility to ensure that the expenses and revenues reported are consistent with and in compliance with each funded service provider's approved budget.

6. It is the LGU's responsibility to ensure that correct program categories, program codes and program code indexes are used.

7. It is the LGU's responsibility to ensure that correct funding codes and funding code indexes are used (See the service provider's approved budget and/or the LGU State Aid Approval Letter).

8. It is the LGU's responsibility to ensure the mathematical accuracy and proper distribution of costs for shared programs. Shared programs are program categories funded by more than one DMH State Agency (OASAS, OMH and/or OMRDD).

9. It is the LGU's responsibility to ensure the proper application of the weighted units of service methodology where appropriate.

10. It is the LGU's responsibility to ensure that total LGU administration expenditures (program code 0890) are allocated to each DMH State Agency in accordance with the DMH approved 1988 percentages found in Appendix K of this manual and the CFR Manual.

11. It is the LGU's responsibility to ensure that agency administration expenses are reported on all county operated and local contract funded not-for-profit service providers claim schedules and are allocated in accordance with the service provider's approved budget.

    Note: At a minimum, total service provider agency administration expenses *must* be allocated to each funding DMH State Agency and each non-DMH State Agency funding source using the ratio value allocation methodology.

12. It is the LGU's responsibility to ensure that any expenses reported that are prohibited by Federal, State or Local laws, regulations and/or policies are adjusted out prior to the reimbursement of State Aid. Please refer to Appendix X of this manual and the CFR Manual for a list of some, but not all, unallowable expenses.

13. It is the LGU's responsibility to ensure that reported expenses are not allocable to or included as an expense of any other program in a prior, current or subsequent fiscal reporting period.

14. It is the LGU's responsibility to ensure that revenues are credited to the appropriate program categories and are reported in accordance with the revenue allocation methodology in each service provider's approved budget.

    OMH Note: *Participants of Community Support Program (CSPs) should refer to the CSP Guidelines. These guidelines may be found in the general provisions section of the spending plan guidelines.*

15. For programs with measurable units of service, it is the LGU's responsibility to review county operated and local contract funded not-for-profit service providers' mid-year claims to ensure that each program is on track to deliver the total units of service committed to in the service providers approved budget (CBR). Furthermore, it is the LGU's responsibility to follow up with those service providers demonstrating serious deviations from their budgeted service delivery commitment to determine the need for technical assistance, budget modification and/or other corrective measures.

16. LGUs will ensure that Article 28 hospital providers approved to use the "Medicaid Option" by the funding DMH State Agency(ies) have reported expenditures and revenues consistent with the "Medicaid Option" procedures described in Appendix Y of this manual and the CFR Manual.

17. It is the LGU's responsibility to identify service provider expenditure overruns, revenue shortfalls, and significant service delivery performance variances If warranted, it is the responsibility of the LGU to ensure that the affected service providers:

    - receive needed technical assistance and/or
    - prepare a budget modification in accordance with specific DMH State Agency and LGU requirements and/or
    - take the appropriate corrective measures to rectify fiscal and/or programatic deficiencies.

18. It is the LGU's responsibility to ensure that service providers use the same method of accounting to budget for and report expenditures and revenues. Service providers *cannot* change their method of accounting without expressed written approval by the funding DMH State Agency(ies) *prior* to implementation.

19. It is the LGU's responsibility to ensure that service providers have taken any and all appropriate measures to maximize the revenues they receive from all other sources.

LGU Mid-Year Fiscal Reporting Requirements

The LGU fiscal reporting requirements and associated responsibilities that follow apply to the mid-year claim schedules for the LGU itself, funded county operated service providers and local contract funded not-for-profit service providers.

Note: *OMH does not require the submission of mid-year claims from LGUs.*

1. The LGU will receive mid-year Agency Quarterly Fiscal Summaries (CQR-1s) from all county operated and local contract funded not-for-profit service providers receiving State Aid through the LGU. These mid-year CQR-1s will report expenses, revenues, net operating costs and funding code information for the first six (6) months of the fiscal reporting period.

   LGUs should follow up immediately with service providers that are delinquent in reporting to ascertain the reasons for lateness and to obtain an estimate of the submission date. If the LGU has good reason to believe that a delinquent reporting service provider will not submit its mid-year or final claiming schedules prior to the required claim submission deadlines, the LGU should proceed with completion of the CQR-3 and State aid claim package.

2. It is the LGU's responsibility to ensure that county operated and local contract funded not-for-profit service providers have completed their CQR-1s in accordance with the instructions contained in this manual.

3. It is the LGU's responsibility to review county operated and local contract funded not-for-profit service providers' mid-year claims to ensure that the fiscal information reported is in compliance with the service provider's approved budget.

4. After receipt and review of all county operated and local contract funded not-for-profit service provider's mid-year claiming schedules, the LGU will prepare an LGU Quarterly Funding Summary (CQR-3) in accordance with the instructions provided in this manual. *Service providers and/or programs funded by a direct contract with a funding DMH State Agency are not included on the mid-year CQR-3.*

5. LGUs will prepare a Mid-year claim package for each funding DMH State Agency consisting of:

   OASAS: OASAS expects all county operated and local contract funded not for profit service providers to complete Mid-Year Fiscal Reporting documents and to submit those documents via the Internet. At this time, paper copies are still required to be sent directly to OASAS' Bureau of Financial Management.

LGU Final Fiscal Reporting Requirements

The LGU fiscal reporting requirements and associated responsibilities that follow apply to the final year-end claim schedules for the LGU itself, funded county operated service providers and local contract funded not-for-profit service providers.

1. LGUs will receive final year-end State Aid claiming schedules from all county operated and local contract funded not-for-profit service providers. The final year-end claiming schedules are included as part of the year-end Consolidated Fiscal Report (CFR) and are referred to as the Consolidated Claim Report (CCR). CCRs consist of CFR schedules CFR-i, CFR-iii, DMH-2, DMH-2A (OASAS and OMRDD Only) and DMH-3.

2. It is the LGU's responsibility to ensure service providers have completed their CCRs in accordance with the instructions provided in the Consolidated Fiscal Reporting and Claiming Manual.

3. It is the LGU's responsibility to ensure that service providers have prepared their CCRs using the same methodologies and principles used in their approved budgets and mid-year claims.

4. LGUs will prepare a final claim package for each funding DMH State Agency consisting of:

   OASAS: OASAS expects all county operated and local contract funded not for profit service providers to complete Final Fiscal Reporting documents and to submit those documents via the Internet. At this time, paper copies are still required to be sent directly to OASAS' Bureau of Financial Management.

   OMH: OMH does not require LGU submission of paper final year-end claim packages. The Aid to Localities Fiscal System (ALFS) will create the LGU claim and summary.

   OMRDD:

   i. Paper copies of CCRs for each county operated and local contract funded service provider funded through a local contract.

   ii. A paper copy of an LGU Fiscal Summary (CQR-3) reporting funding code information for all county operated and local contract funded not-for-profit service providers.

   iii. A State Aid Voucher (AC-1171) with an original signature completed in accordance with Section 21 of this manual.

   Please see section 17.0 of this manual for more instructions on the preparation and submission of LGU final claim packages including where to mail the paper copies.

5. LGUs will submit the completed final year-end claim package(s) for receipt by the funding DMH State Agency(ies) as follows:

   OASAS: LGU final claim packages are due for receipt by OASAS no later than 120 days after the end of the fiscal reporting period.

   OMH: LGU final claim packages are due for receipt by OMH no later than 135 days after the end of the fiscal reporting period. (165 days if 30 day CFR Extensions have been submitted.)

   OMRDD: LGU final claim packages are due for receipt by OMRDD no later than 135 days after the end of the fiscal reporting period. (165 days if 30 day CFR Extensions have been submitted.)

This section of the manual outlines the policies and procedures regarding the development and processing of Aid to Localities (State Aid) advance payments. Advance payments are provided two (2) ways:

1. to Local Governmental Units (LGUs) for pass through to county operated and local contract funded not-for-profit service providers, and

2. to county operated and not-for-profit service providers funded through a direct contract with one or more of the DMH State Agencies.

Advance payments are provided to these two (2) groups of funded service providers to facilitate the consistent and timely flow of State Aid used to finance approved program operations. The policies and procedures regarding advance payments are different for LGUs and direct contract funded service providers. Additionally, each DMH State Agency has differing advance payment policies for LGUs and direct contract funded service providers.

Specific advance payment policies, procedures and requirements for LGUs and direct contract funded service providers are described below.

Advance Payments - Local Governmental Units (LGUS) – All DMH State Agencies

The policy of the DMH State Agencies is to provide regular periodic advance payments to LGUs based on the following conditions:

1. Subject to State appropriations availability, DMH State Agencies will make advance payments to county local governments as follows:

   OASAS: OASAS may provide advance payments to LGUs from State funds and/or Federal funds as follows:

   State Funds: Advance payments will be developed quarterly for payment within the first 10 days of the first month of each calendar quarter (January, April, July and October).

   Federal Funds: Advance payments will be developed monthly for payment within the first 10 days of each month (January, February, March, April, May, etc.).

   For LGUs receiving State Aid consisting of both State and Federal funds, each quarterly advance will include three (3) months of State funds and one (1) month of Federal funds payable within the first 10 days of the first month of each calendar quarter. The LGU will then receive two (2) one (1) month advance payments for the remaining two (2) months of the quarter payable within the first 10 days of each month.

   State and Federal funds are identified on the OASAS Approval letter

by the alphabetic funding source code associated with the three (3) digit numeric funding code (i.e. 001S, 013F, etc.).
Please see Appendix N of this manual and/or the Consolidated Fiscal Reporting and Claiming (CFR) Manual for a description of OASAS alphabetic funding source codes.

OMH: Advance payments for LGUs will be processed quarterly for payment within the first 10 days of the first month of each calendar quarter (January, April, July and October) in accordance with Article 41.15(d) of Mental Hygiene Law.

OMRDD: Advance payments for LGUs will be processed quarterly for payment within the first 10 days of the first month of each calendar quarter (January, April, July and October) in accordance with Article 41.15(d) of Mental Hygiene Law.

2. *OASAS* and *OMRDD* advance payments for the April - June quarter and the quarters that follow are subject to:

   i. the timely passage of New York State Budget appropriations for the fiscal reporting period,

   ii. approval of budget certificates by the NYS Division of the Budget, and

   iii. segregation of the appropriated funds by the Office of the State Comptroller.

   OMH April - June advance payments are not affected by passage of New York State Budget Appropriations in April. However, July – September and October – December advance payments are subject to the three (3) conditions stated above.

3. Generally, 100% of an LGU's approved State Aid allocation will be advanced for a fiscal reporting period. However, at the discretion of the funding DMH State Agency, total advance payments provided may be limited to ninety percent (90%) of an LGU's approved State Aid allocation.

4. At the discretion of the funding DMH State Agency, advance payments may be adjusted to reflect the actual fiscal reporting experience of county operated and local contract funded service providers.

5. At the discretion of the funding DMH State Agency, LGU advance payment amounts may be reduced as a result of delinquent county operated and local contract funded service provider budgets, contracts or claim submissions, delinquent submission of signed State Aid funding Authorizations (OASAS only), Disproportionate Share (DSH) Memorandums of Understanding (OASAS only) and/or serious under spending. Generally, these reductions will not be applied to those service providers that have established cyclical spending patterns.

6. LGUs must forward advance payments to all local contract funded service providers *within 30 days of the advance's receipt by the LGU*. Advances should be made in accordance with the contractual advance payment schedule. LGUs shall have discretionary authority to withhold advances from service providers not in compliance with reporting requirements.

7. DMH State Agency processing of LGU advances for payment by the Office of the State Comptroller is also predicated on the following requirements:

Quarter	*Requirement*	*Due Dates Counties*	*NYC*
1	Receipt of current year Workscope & CBR by Field Office (OASAS)	October 1st of prior fiscal year	April 1tstof prior fiscal year
2	Receipt of current year final budgets (OMRDD)	February 15th of current fiscal year	Use NYC DOHMH guidelines
	Receipt of signed current year State Aid Funding Authorization (OASAS)	February 15th	August 15th
3	Receipt of current year LGU contracts (OMRDD)	April 30th	December 31st
	Receipt of prior year final claim (OASAS)	May 1st	November 1st
	Receipt of final claim (OMH & OMRDD)	May 15th	November 15th
	Receipt of current year final budgets (OMH)	November 1st	October 1st
4	Receipt of mid-year claim for the current fiscal year (OASAS & OMRDD)	August 15th	February 15th

***Note**: In accordance with Section 41.18(b) of Mental Hygiene Law (MHL) local governments shall be granted State Aid for approved net operating costs pursuant to an approved Local Services Plan. No State Aid may be paid without an approved Local Plan.*

Federal regulations prohibit making payments from Federal funds to any service provider that has not filed the required Federal compliance assurances with the funding DMH State Agency(ies).

8. Each individual DMH State Agency will carefully monitor performance in meeting the above requirements. Requirements not met in a specific quarter will be carried over to succeeding quarters. Non-compliance with these requirements may result in advances being reduced or not processed at all.

9. If the LGU or individual service provider comes into compliance within 30 days after the beginning of the quarter, an individual DMH State agency may process an "off-

cycle" advance payment; otherwise, the individual DMH State Agency may postpone payment until the next scheduled advance payment date.

Advance Payments - OASAS Direct Contractors

Advances are made in accordance with the payment schedule indicated in Appendix C of each fully executed contract. Advances may be withheld or reduced if any of the conditions specified in the contract or guidelines have not been met.

1. The policy of OASAS is to provide advance payments to direct contract-funded service providers based on the following criteria:

   i. A contract between OASAS and the direct contract-funded service provider has been approved and fully executed by the State Attorney General and the Office of the State Comptroller; and

   ii. The direct contract-funded service provider has submitted to OASAS the appropriate number of State Aid Vouchers (AC-1171s) for advance payment processing (see note following Item 4 below). These vouchers should be submitted when returning the service provider signed copies of the contract agreement to OASAS or in response to receiving the initial Contract Budget and Funding Summary (Appendix B) for each budget period of the contract.

   iii. OASAS may provide advance payments from State funds and/or Federal funds as follows:

   State Funds: Advance payments will be developed quarterly for payment within the first 10 days of the first month of each calendar quarter (January, April, July and October).

   Federal Funds: Advance payments will be developed monthly for payment within the first 10 days of each month (January, February, March, April, May, etc.).

   For contractors receiving State Aid consisting of both State and Federal funds, each quarterly advance will include three (3) months of State funds and one (1) month of Federal funds payable within the first 10 days of the first month of each calendar quarter. The Contractor will then receive two (2) one (1) month advance payments for the remaining two (2) months of the quarter payable within the first 10 days of each month.

State and Federal funds are identified on the Appendix B by the alphabetic funding source code associated with the three (3) digit numeric funding code (i.e. 013S, 013F, etc.).

Please see Appendix N of this manual and/or the Consolidated Fiscal Reporting and Claiming (CFR) Manual for a description of OASAS alphabetic funding source codes.

2. A final payment, if needed, will be made to the direct contractor based on the fiscal data reported on the DMH-2, DMH-2A and DMH-3 State Aid claiming schedules of the Consolidated Fiscal Report.

3. An optional fifth quarter payment *may be provided at OASAS' discretion ,* based on the following criteria:

   i. Service provider receipt of a Written Directive signed by OASAS.

   ii. Must be allowed for in the current service provider direct contract agreement.

   iii. The service provider has submitted a State Aid Voucher (AC-1171) for the fifth quarter payment.

4. Prior period overpayments and/or audit recoveries can be recouped against any payment OASAS makes to a direct contract-funded service provider. The recoupment generally begins with the first payment made to the direct contract-funded service provider following OASAS identification of the overpayment and/or audit recovery amount.

Note: *Direct contract-funded service providers receiving NYS General Fund State aid only must submit four (4) advance vouchers annually.*

Direct contract-funded service providers receiving Federal funds as all or part of their approved State Aid must submit 12 advance vouchers annually.

Vouchers should have the Name and Address sections completed, reference the contract number in the Description section and be signed by an authorized official in blue or black ink.

State and Federal funds are identified by the alphabetic funding source code associated with the three (3) digit numeric funding code on Appendix B of OASAS direct contract agreements (i.e. 013F, 001S, etc.).

Please see Appendix N of this manual and/or the Consolidated Fiscal Reporting and Claiming (CFR) Manual for a description of OASAS alphabetic funding source codes.

Advance Payments - OMH Direct Contractors

The policy of the Office of Mental Health is to provide four advances to contracts that are operational, plus one optional payment if needed. Start-up contracts receive an initial advance and the remainder as specified in the contract/guidelines.

The payment of an advance is based on the following conditions:

1. The contract has been approved by the State Attorney General and the Office of the State Comptroller.

2. Requirements stated in the contract/guidelines have been met, such as the submission of an expenditure report or a program report.

3. The optional payment or fifth quarter payment is based on the following:

    i. A Written Directive signed by the Director of Community Budget Service.

    ii. Must be allowed for in the current contract.

4. Advances are made in accordance with the payment schedule in each contract. Advances may be withheld or reduced if any of the conditions specified in the contract or guidelines have not been met.

5. Prior period overpayments and/or audit recoveries can be recouped against any payment OMH makes to a direct contract service provider. The recoupment generally begins with the first payment made to the direct contract service provider following OMH identification of the overpayment and/or audit recovery amount.

Advance Payments - OMRDD Direct Contractors

The policy of the Office of Mental Retardation (OMRDD) is to provide quarterly advance payments to direct contracts based on the following:

1. The contract has been approved by the State Attorney General and the Office of the State Comptroller.

2. Direct contract agencies shall submit to OMRDD a State Aid Voucher (AC-1171) requesting an advance representing the approved limit established in the approved contract.

3. The combined amount of the first and second quarter advance shall be limited to fifty percent (50%) of the annualized State Aid contract amount.

4. The State Aid Voucher submitted for the third quarter advance shall be accompanied by an agency Fiscal Summary (CQR-1) and, if appropriate, an Agency Quarterly Program Report Summary for the first quarter. The amount of the third quarter advance will be adjusted to reflect fiscal activity reported in the first quarter (CQR-1)

and in no case shall exceed 25% of the State Aid contract amount.

a. For Direct Sheltered Workshop contracts, either the first quarter approved net expenditures or contract sales, whichever is lower, is the basis for adjusting the third quarter advance.

b. For all other contracts, the third quarter advance will be adjusted to reflect fiscal activity reported in the first quarter and in no case shall exceed 25% of the State Aid contract amount.

5. The State Aid Voucher submitted for the fourth quarter advance shall be accompanied by an agency Fiscal Summary (CQR-1) and, if appropriate, an Agency Quarterly Program Report Summary for the second quarter. The amount of the fourth quarter advance will be adjusted to reflect fiscal activity reported on the second quarter less a 10% hold back of the total contract amount. An exception to this would be made for the Direct Sheltered Workshop contracts. For them, either the second quarter approved net expenditures or contract sales, whichever is lower, is the basis for adjusting the fourth quarter advance.

6. A final payment, if needed, will be made to the direct contractor based on the fiscal data indicated in the Consolidated Fiscal Report.

   For Direct Sheltered Workshop contracts, the basis for final payment will be either approved net expenditures or contract sales, whichever is lower.

7. The optional advance payment is based on the following:

   i. Payment of the optional advance payment must be approved by the local DDSO.

   ii. The receipt of a voucher (AC-1171) by the Bureau of Community Funding. Prior year overpayments and audit recoveries can be recovered against any payment being paid to a voluntary local service provider. Usually recovery will begin against the next available payment.

8. Prior year overpayments and audit recoveries can be recovered against any payment being paid to a voluntary local service provider. Usually recovery will begin against the next available payment.

New York State
Consolidated Budget Report
Document Submission Matrix

Does the service provider operate:

OASAS State Aid funded programs and/or
OMH State Aid funded programs and/or
OMRDD programs

No → No Consolidated Budget Report is required

Yes ↓

Does the service provider operate any of the following OMRDD programs:

Day Treatment Programs;
Intermediate Care Facilities or
HCBS Waiver Funded Programs?

No → OASAS, OMH and all other OMRDD programs must complete schedules:

CBR-i
CBR-4
DMH-2 - Budget
DMH-2A – Budget *
DMH-3 – Budget

* Not applicable for OMH funded programs

Yes ↓

Budgets for these program types are only required for new site development. When opening a new site, please contact the appropriate DDSO Rate Setting Unit for the necessary forms.

Note: The County/NYC Local Governments and the Department of Mental Hygiene may request additional information as they deem necessary.

The CBR-i Consolidated Budget Report schedule is used to capture agency identifying data for county operated and not-for profit service providers operating programs funded and/or certified by one (1) or more of the DMH State Agencies.

Note: *This is the only budget schedule with the agency address. Please ensure that this schedule is included in your submission.*

For the Period

Enter the beginning and ending dates of the budget period covered by the document.

Agency Name

Enter name of the organization (service provider) operating the reported program(s).

Agency Address

Enter the address of the organization operating the reported program(s).

Note: *Please check the box if the organization's headquarters/central administrative office has changed since the last reporting period.*

Agency Code

Enter the five (5) digit code assigned to the organization operating the reported program(s).

County Name

Enter the county where the organization's headquarters/central administrative office is located.

OMH Note: *Service providers located in the five (5) boroughs of the City of New York (Bronx, Kings, New York, Queens and Richmond) should use the county name "New York" on their CBR-i.*

County Code

Enter the two (2) digit county code associated with the county where the organization's headquarters/central administrative office is located. Please see Appendix C of this manual and the Consolidated Fiscal Reporting and Claiming Manual (CFR Manual) for a list of New York State counties and their associated county codes.

OMH Note: *Service providers located in the five (5) boroughs of the City of New York (Bronx, Kings, New York, Queens and Richmond) should use county code "31" on their CBR-i.*

Type of Ownership

Enter the organization's type of ownership:

Not-for-Profit: A group, institution, or corporation formed for the purpose of providing goods and services under a policy where no individual (e.g., stockholder, trustee) will share in any profits or losses of the organization. Profit is not the primary goal of not-for-profit entities. All income and earnings will be used exclusively for the purpose of the corporation and no part shall inure to the benefit of any private individual, firm or corporation.

Proprietary: A privately or publicly owned entity operated for profit.

Governmental: An entity operated by a State, County or Municipality.

Person to Contact

Enter the name, title, email address phone number and fax number of the person that can answer questions about the information contained in the document.

Note: *Please check the box if the person to contact has changed since the last reporting period.*

State Agency(ies)

Indicate the NYS Department of Mental Hygiene (DMH) State Agency(ies) that fund(s)/Certify(ies) the reported program(s). The DMH State Agencies are the Office of Alcoholism and Substance Abuse Services (OASAS), Office of Mental Health (OMH) and the Office of Mental Retardation and Developmental Disabilities (OMRDD).

Date Prepared

Enter date this document was completed.

Number of Pages

Enter the total number of pages submitted including attachments to the Consolidated Budget Report (CBR).

The CBR-4 Consolidated Budget Report (CBR) schedule is used to list budgeted personal services expenses by program type and/or program site and/or contract for programs funded and/or certified by one (1) or more of the DMH State Agencies. Please refer to Section 8 of the Consolidated Fiscal Reporting and Claiming Manual (CFR Manual) for more detailed information on program types and program sites.

The CBR-4 reports the hours worked, amounts paid and full time equivalents (FTEs) associated with each position title (job function) employed by the county operated or not-for-profit service provider.

Two (2) sets of CBR-4s are completed:

i. One (1) set reports program specific personal service expenses, and

ii. One (1) set reports agency administration personal service expenses.

Note: *Article 28 hospitals are not required to complete an agency administration CBR-4 schedule.*

Program Specific CBR-4 General Instructions

1. A separate CBR-4 schedule is completed for each funding DMH State Agency.

2. A separate DMH State Agency specific CBR-4 is completed for each Local Governmental Unit (LGU) funding a program or programs operated by the service provider.

3. Program specific CBR-4s can only include program/site, program administration and/or LGU administration position title codes (100–599 and 700–799).

Agency Administration Specific CBR-4 General Instructions

1. Article 28 hospitals are not required to complete an agency administration CBR-4.

2. Only one (1) agency administration CBR-4 is completed.

3. The agency administration CBR-4 schedule includes the *total* service provider agency administration personal services expenses *not* just those expenses associated with the funding DMH State Agency(ies) and/or LGU(s).

4. Agency administration CBR-4 schedules can only include agency administration position title codes (600-699).

5. All funding DMH State Agencies and/or LGUs must receive a copy of the same agency administration CBR-4 schedule. There cannot be separate CBR-4 schedules with different agency administration personal service expenses sent to each funding DMH State Agency and/or LGU.

General CBR-4 Instructions

These general instructions apply to both the program CBR-4 schedules and the agency administration CBR-4 schedules.

1. Amounts paid *must* be reported in whole dollars.

2. Include anticipated overtime, bonuses and cafeteria plan or split dollar benefits.

3. Calculate FTEs to three (3) decimal places.

4. Employee hours worked, amounts paid and FTEs must be allocated if any of the following circumstances occur:

    i. The employee works at more than one (1) program.

    ii. The employee works in programs funded by more than one (1) DMH State Agency and/or LGU.

    iii. The employee works in more than one position title (job function).

    Please see Appendix J and/or Appendix L of this manual and the Consolidated Fiscal Reporting and Claiming Manual (CFR Manual) for more information on allocating expenses.

Heading Instructions

For the Period *

Enter the beginning and ending dates of the budget period covered by the document.

State Agency *

Indicate the DMH State Agency(ies) that fund(s) and/or certify(ies) the reported programs.

Agency Name *

Enter the name of the organization (service provider) operating the reported program(s).

Agency Code *

Enter the five (5) digit code assigned to the organization operating the reported program(s).

** Complete this at the top of each page of the CBR-4.*

Staffing Category

Check the appropriate staffing category. Each of the two staffing categories must be reported on a separate page.

Staffing Category	*Position Title*	*Position Title Codes*
Program/Site	Support	100 through 199
	Direct Care	200 through 299
	Clinical	300 through 399
	Production	400 through 499
	Program Administration	500 through 599
	LGU Administration	700 through 799
Agency Administration	Agency Administration	600 through 699

Note: *All agency administration staff for the entire corporate entity must be reported on a separate schedule in a single column. One and only one CBR-4 schedule for Agency Administration must be completed per service provider.*

Article 28 Hospitals are not required to detail agency administration staff.

Column Number (Leave blank for the agency administration CBR-4 schedule)

For each program reported, assign a column number. Label programs in consistent column order within each funding DMH State Agency's schedules. Programs *must* be assigned the same column number throughout all schedules of the CBR. Additional program/sites should be assigned the next sequential column number on additional pages if necessary.

Note: *Approved Consolidated Fiscal Reporting System (CFRS) software automatically assigns and organizes column numbers.*

Program Code and Program Code Index (Leave blank for the agency administration CBR-4 schedule)

For each reported program, enter the applicable DMH State Agency program code and program code index. Please see Appendices E, F and G of this manual and the CFR Manual for complete listings of valid program codes. Program code indexes are assigned as follows:

OASAS: Use the same array of program codes and indexes as were used during the prior reporting period unless programs have been added or removed from OASAS funding for this reporting period. If programs have been added or removed from OASAS funding, consult with the OASAS Field Office for the appropriate array of program codes and indexes to be used.

OMH: Use the same array of program codes and indexes as were used during the prior reporting period unless programs have been added or removed from OMH funding for this reporting period. If programs have been added or removed from

OMH funding, consult with the OMH Field Office for the appropriate array of program codes and indexes to be used.

OMRDD: OMRDD programs reported on a program type basis (expenses and revenues aggregated and reported in one (1) column) and programs codes 0053, 0054, 0090, 0091, 0200, 0202, 1090, 1091, 2090, 2091, 3090, 4090, 5090, 5091, 6090 and 6091use index code "00". For all other OMRDD programs use "01" for the first occurrence of each program type, "02" for the second occurrence, "03" for the third occurrence, etc (e.g. Family Support).

County Code

Enter the county code of the county where the budgeted services will be provided and/or funded through a local contract. Please see Appendix C of this manual and the CFR Manual for a list of New York State counties and their associated county codes.

OMH Note: *Service providers located in the five (5) boroughs of the City of New York (Bronx, Kings, New York, Queens and Richmond) should use county code "31" for all reported programs.*

Position Title Code

For each reported program, enter the appropriate position title code using the job descriptions listed in Appendix R of this manual and the CFR Manual.

The following rules and restrictions apply to position title code reporting:

i. Select the position title code code (s) for the position title description that most closely describes the employee's(s') job function.

ii. Certain position title codes are only valid for specific DMH State Agencies and/or specific types of programs

iii. Multiple employees with the same position title code and the same standard work week must be combined and reported on the same line. Position title codes can only be used more than once if employees in the same position title code work different standard work weeks.

iv. Employees performing job duties relating to more than one position title must be reported using all applicable Position Title Codes based on the hours worked in each different job function.

Position Title

For each reported program, enter the appropriate position title(s) for the Position Title Code(s) used.

Standard Work Week

Check the standard number of hours (35, 37.5 or 40) to be worked per week for a full time employee by indicating "x" in the corresponding box. If the standard work week differs from what is pre-printed on the schedule, check "other" and note the number of hours. *A standard work week cannot be less than 35 hours nor more than 45 hours.*

Note: *When reporting an employee who works part-time, check the number of standard work week hours the employee would be required to work if they were a full time employee. For example, if a social worker regularly works 20 hours, but would be required to work 40 hours as a full time employee, the standard work week is 40, not 20 hours per week.*

Hours Paid

For each program reported, enter the total budgeted hours to be paid all employees within the position title for the reporting period. This total must include all overtime. Overtime *must* be reported as straight time. For example, 10 additional hours paid at time and one half should be reported as 10 hours, not 15 hours.

Note: *If an employee works in multiple job titles and/or works at multiple programs/sites, allocate the hours paid for each job title and/or program/site using methodology explained in Appendix J and/or Appendix L of this manual and the CFR Manual.*

Full Time Equivalent (FTE)

For each program reported, calculate the FTE for each Position Title Code to three (3) decimal places. Divide the number of hours paid by the product of the standard full time work week times 52 weeks per year.

Example 1: A social worker has a standard work week of 35 hours and will work 25 hours a week for 40 weeks:

$$\frac{25}{35} \times \frac{40}{52} = \frac{1000}{1820} = .549 \text{ FTEs}$$

Example 2: A psychologist has a standard work week of 37 ½ hours and will work 37 ½ hours a week for 52 weeks:

$$\frac{37.5}{37.5} \times \frac{52}{52} = \frac{1950}{1950} = 1.000 \text{ FTEs}$$

Note: *Approved Consolidated Fiscal Reporting System (CFRS) software automatically calculates FTEs.*

Amount Paid

For each reported program, enter the amount to be paid to all employees within each position title for the reporting period. The amount must be reported in whole dollars and include all overtime, bonuses, and cafeteria or split dollar benefits.

Note: *If an employee works at multiple programs/sites, allocate the amount paid to each program/site as explained in Appendix J and/or Appendix L.*

Total FTE

For each program reported, enter the total FTEs.

Total Amount Paid

For each reported program, enter the total amount to be paid.

The DMH-2 (Budget) schedule of the Consolidated Budget Report (CBR) is used to list budgeted expenses, revenues, net operating costs and deficit funding amounts by program type and/or program site and/or contract number for programs funded and/or certified by one (1) or more of the DMH State Agencies. Please refer to Section 8 of the Consolidated Fiscal Reporting and Claiming Manual (CFR Manual) for more detailed information on program types and program sites.

The following guidelines should be followed in completing this schedule:

1. A separate DMH-2 (Budget) schedule *must* be prepared for each DMH State Agency from which the service provider receives Aid to Localities (State Aid) funding. Aid to Localities funding may be provided directly through a contract with a DMH State Agency or indirectly through a contract with the Local Governmental Unit (LGU).

2. A separate DMH-2 (Budget) schedule *must* be prepared for each county in which the service provider operates programs and receives Aid to Localities (State Aid) funding. Aid to Localities funding may be provided directly through a contract with a DMH State Agency or indirectly through a contract with the Local Governmental Unit (LGU).

3. The programs reported on the DMH-2 (Budget) schedule *must* be arrayed in the same order as they appear on schedules CBR-4, DMH-2A and DMH-3.

4. Total service provider agency administration expenses *must* be allocated among the funding DMH State Agencies using the ratio value methodology. Each funding DMH State Agency's share of agency administration is allocated among that DMH State Agency's funded and/or certified programs as follows:

   OASAS: The total OASAS share of agency administration may be allocated among OASAS programs using ratio value or an approved alternative methodology. The allocation methodology used *must* remain constant from year-to-year and cannot be changed without prior OASAS and, if applicable, LGU approval.

   OMH: The total OMH share of agency administration may be allocated among OMH programs using ratio value or an approved alternative methodology. The allocation methodology used *must* remain constant from year-to-year and cannot be changed without prior OMH and, if applicable, LGU approval.

   OMRDD: The total OMRDD share of agency administration *must* be allocated among OMRDD programs using the ratio value methodology.

5. Equipment purchases for the reporting period are budgeted as follows:

OASAS : All equipment *must* be expensed in the year of purchase. OASAS does not allow service providers to budget or claim asset depreciation for State Aid reimbursement.

OMH: Equipment purchases for the reporting period may be expensed or capitalized (depreciated) over the life of the asset.

OMRDD: Equipment purchases for the reporting period may be expensed or capitalized (depreciated) over the life of the asset.

Note: *If equipment is expensed in the year of purchase, the service provider must use cash or modified accrual accounting on the DMH-2 (Budget), DMH-2A (Budget) and DMH-3 (Budget) schedules.*

Heading Instructions

For the Period *

Enter the beginning and ending dates of the budget period covered by this document.

State Agency *

Indicate the DMH State Agency(ies) that fund(s) and/or certify(ies) the reported programs.

Agency Name *

Enter the name of the organization (service provider) operating the reported program(s).

Agency Code *

Enter the five (5) digit code assigned to the organization operating the reported program(s).

Date Prepared *

Enter the date the DMH-2 (Budget) schedule was prepared.

County Name and Code *

Enter the name and associated code of the county where the budgeted services will be provided and/or funded through a local contract or, a direct contract with a DMH State Agency. Please see Appendix C of this manual and the Consolidated Fiscal Reporting and Claiming Manual (CFR Manual) for a list of New York State counties and their associated

county codes.

OMH Note: *Service providers located in the five (5) boroughs of the City of New York (Bronx, Kings, New York, Queens and Richmond) should use the county name "New York" and the county code "31" for all reported programs.*

* *Complete this at the top of each page of the DMH-2 (Budget).*

Prepared by *

Enter name of person that prepared the DMH-2 (Budget) schedule and can answer questions about the information it contains.

Telephone *

Enter the preparer's telephone number.

Column Number

For each program reported, assign a column number. Label programs in consistent column order within each funding DMH State Agency's schedules. Programs *must* be assigned the same column number throughout all schedules of the CBR. Additional programs must be assigned the next sequential column number on additional pages when necessary.

Note: *Approved Consolidated Fiscal Reporting System (CFRS) software automatically assigns and organizes column numbers.*

* *Complete this at the top of each page of the DMH-2 (Budget).*

Line Instructions

1. Accounting Method

For each reported program, enter the method of accounting used i.e., accrual, modified accrual or cash. Please refer to Section 3.0 of this manual for more information on accounting methods.

2. State Contract Number/LGU Contract Number

For each reported program, enter the contract number as follows:

State Contract Number: For direct contracts with a funding DMH State Agency, enter the State Contract Number.

LGU Contract Number: For local county contracts, enter the LGU Contract Number if applicable. A contract number *must* be entered. If there is no county contract number assigned to the program enter the applicable county name or county abbreviation (up to 7 characters).

OASAS Note: *The contract number used for each reported program on the DMH-2 (Budget) schedule must match the contract number used for all funding source codes (except funding source code 090) for that program on the DMH-3 (Budget) schedule*

OMH Note: *The contract number used in each column (Unique program code + program code index) of the DMH-3 (Budget) schedule should consist of a single State direct contract number or an appropriate combination of local contract numbers. Direct and local contract numbers cannot be used in a single column on the DMH-3 (Budget) schedule.*

OMRDD Note: *There may be both direct contract numbers and local contract numbers in the same column (program code) of the DMH-3 (Budget) schedule. Each funding source code may have a unique contract number. At least one (1) contract number and associated type of contract (State or local) must match the contract number and type of contract in the same column (program code) of the DMH-2 (Budget) schedule.*

3. Program Type

For each reported program, enter the type of program operated using the program names in Appendices E, F and G of this manual and the CFR Manual.

4. Program Code & Program Code Index

For each reported program, enter the applicable DMH State Agency program code and program code index. Please see Appendices E, F and G of this manual and the CFR Manual for complete listings of valid program codes. Program code indexes are assigned as follows:

OASAS:

i. Use the same array of program codes and indexes as were used during the prior reporting period unless programs have been combined, added or removed from

OASAS funding for this reporting period. If programs have been added or removed from OASAS funding, consult with the OASAS Field Office for the appropriate array of program codes and indexes to be used.

OMH:

i. Use the same array of program codes and indexes as were used during the prior reporting period unless programs have been added or removed from OMH funding for this reporting period. If programs have been added or removed from OMH funding, consult with the OMH Field Office for the appropriate array of program codes and indexes to be used.

ii. For OMH Community Residences, each supervised site, each MI/MR site and each Children and Youth site is considered a program and must be reported in a separate column.

iii. For OMH start up program and PDG program codes and indexes, see Appendix F of this manual and the CFR Manual.

OMRDD:

i. OMRDD programs reported on a program type basis (expenses and revenues aggregated and reported in one (1) column) and programs codes 0053, 0054, 0090, 0091, 0200, 0202, 1090, 1091, 2090, 2091, 3090, 4090, 5090, 5091, 6090 and 6091 use index code “00”. For all other OMRDD programs use “01” for the first occurrence of each program type, “02” for the second occurrence, “03” for the third occurrence, etc (e.g. Family Support).

EXPENSES

5. Personal Services

For each reported program, enter the anticipated total personal services expenses for the reporting period from the CBR-4 schedule. *Do not include agency administration personal services on this line.*

Note: *Personal services expenses must be reasonable and necessary for providing services.*

6. Vacation Leave Accruals

For each reported program, enter the anticipated vacation leave accruals corresponding to the personal services listed on Line 5. *Do not include agency administration leave accruals on this line.*

OASAS Note: *OASAS does not allow service providers to budget for or claim vacation leave accruals for Aid to Localities (State Aid) reimbursement.*

7. Fringe Benefits

For each reported program, enter the anticipated fringe benefits expenses corresponding to the personal services listed on Line 5. Include FICA, hospitalization, retirement benefits, group life insurance, etc. *Do not include agency administration fringe benefits on this line.*

Note: *Fringe benefits expenses are allowable expenses to the extent that they are reasonable and available to all employees.*

8. Other Than Personal Services (OTPS)

For each reported program, enter the anticipated OTPS expenses for the reporting period. Include food, repairs and maintenance, utilities, telephone and minor expensed equipment (equipment costing less than $1,000 or having a useful life of less than two years).

9. Equipment Provider Paid

For each reported program, enter the anticipated equipment related expenses for the reporting period. Include vehicle and equipment lease costs. *Do not include agency administration equipment costs on this line.*

Note: *Do not include any equipment budgeted as minor expensed equipment in OTPS (line 8) or Agency Administration.*

OASAS Note: *OASAS does not allow service providers to budget for or claim equipment depreciation expenses for Aid to Localities (State Aid) reimbursement. All equipment must be expensed in the year of purchase.*

10. Property-Provider Paid

For each reported program, enter the anticipated property related expenses for the reporting period. Include property lease costs and/or depreciation, real estate taxes (if allowable), property and casualty insurance, etc., if applicable. *Do not include agency administration property costs on this line.*

OASAS Note: *OASAS does not allow service providers to budget for or claim property related depreciation expenses for Aid to Localities (State Aid) reimbursement.*

OMH Note: *OMH Community Residence and Family Based Treatment providers should refer to the OMH Aid to Localities Spending Plan Guidelines.*

11. Agency Administration

For each reported program, enter the anticipated agency administration expenses for the reporting period. Except as noted below, *all* county operated programs and *all* not-for-profit service provider programs must be allocated agency administration expenses.

Note: County operated service providers *must* allocate agency administration expenses to programs other than LGU administration (program code 0890). LGU administration is considered a unique cost center separate and distinct from agency administration expenses incurred by other county operated programs. Agency administration expenses for the management and oversight of all county operated programs other than program code 0890 *cannot* be included in the expenses reported under program code 0890. Please see Appendix I and Appendix K of this manual and the CFR Manual for more detailed information on agency administration and LGU administration.

Agency administration is allocated to the DMH State Agencies and their programs using a two (2) step process:

Step 1:

Allocate the organization's (service provider's) agency administration expenses between each of the funding DMH State A *total* agencies and *all* other funding sources using the ratio value allocation methodology.

The following programs are exempt from agency administration and are not included in the Step 1 ratio value calculation:

- LGU Administration (0890),
- Program Development Grants (OMRDD), and

Step 2:

For OASAS: Allocate the total OASAS share of agency administration to each OASAS program using the existing OASAS approved allocation methodology. Please note that OASAS prefers and recommends the use of the ratio value allocation methodology.

For OMH: Allocate the total OMH share of agency administration to each OMH

program using the existing OMH approved allocation methodology.

Within the OMH DMH-2 (Budget) schedules, the following programs are exempt from agency administration and are not included in the Step 2 ratio value calculation:

- LGU Administration – OMH Reinvestment and MGP (0860).
- Monitoring and Evaluation, CSS (0870),
- FEMA Crisis Counseling Assistance and Training (1690)
- Client Service Dollars – Non ICM/SCM/ACT (2820)
- Conference of Mental Hygiene Directors (2860)
- ICM/SCM/BCM Emergency and Non-Emergency Service Dollars (2830)
- Start-up programs with an ”A” as the program code index.
- Assertive Community Treatment (ACT) Team – Service Dollars (8810)

For OMRDD: Allocate the total OMRDD share of agency administration to each OMRDD program using the ratio value allocation methodology. Within the OMRDD DMH (Budget) schedules, the following programs are exemptfrom agency administration and are not included in the Step 2 ratio value calculation:

- VOICF/DD, Sheltered Workshop not operated by service provider (2091)
- VOICF/DD, School District Contracts not operated by service provider (3091)
- VOICF/DD, Day Training not operated by service provider (5091)
- VOICF/DD, Day Services Contract (7090)

12. Adjustments/Non-Allowable Costs

For each reported program, enter the anticipated adjustment to expenses and/or non-allowable costs. Refer to Appendix X of this manual and the CFR Manual for further

details.

13. Total Adjusted Expenses

For each reported program, enter the sum of lines 5 through 11 minus line 12.

Revenues

14. Participant Fees (less SSI & SSA)

For each reported program, enter the anticipated fee payments expected directly from program participants for the reporting period. The amount entered here will be the amount in excess of anticipated SSI and SSA payments made on behalf of program participants..

15. SSI & SSA

For each reported program, enter the anticipated amount of Supplemental Security Income and the Social Security Income expected from program participants for the reporting period.

16. Home Relief

For each reported program, enter the anticipated amount of Home Relief revenue for the reporting period such as Congregate Care.

17. Medicaid Regular

For each reported program, enter the anticipated amount of Medicaid revenue expected for the reporting period.

Medicaid Managed Care: *Revenues received directly from a Medicaid Managed Care organization should not be reported here. It should be reported on line 19, Other Third Parties.*

Disproportionate Share (DSH): *OASAS and OMH service providers receiving Disproportionate Share (DSH) revenue should budget DSH revenues on line 29, Other Revenue.*

OMH Note: *Include the anticipated Community Support Program (CSP) Medicaid revenue expected during the local fiscal year. For budgeting purposes, include the CSP revenue in the column of the appropriate CSP program; for claiming purposes, include the CSP revenue in the column*

of the licensed outpatient program (clinic, CDT, or day treatment program) generating the CSP revenue. See Appendix DD of this manual and the CFR Manual for more information on COPS and CSP Medicaid revenue.

18. Medicare

For each reported program, enter the anticipated Medicare revenue expected for the reporting period.

19. Other Third Parties

For each reported program, enter the anticipated revenue expected from managed care organizations and third party payers (such as Blue Cross, commercial pay, Champus, etc.) for the reporting period.

20. OMRDD Residential Room and Board/NYS OPTS

Make no entry. Not applicable for OMRDD CBRs.

21. Transportation, Medicaid

For each reported program, enter the anticipated Medicaid transportation revenue expected for the reporting period.

22. Transportation, Other

For each reported program, enter the anticipated transportation revenue expected for the reporting period that is *not* included on line 21.

23. Sales: Contract Total

For each reported program, enter the anticipated *industrial* sales contract revenue expected for the reporting period.

OASAS Note: *Report anticipated Employee Assistance Program (EAP) revenues on this line.*

24. Federal Grants (Attach detail)

For each reported program, enter the anticipated Federal grant revenues expected for the reporting period. Only include those grants received *directly* from an administering Federal Government agency that are specifically part of a program funded by one of the DMH State Agencies.

Do not include Federal grant revenue received as pass through State Aid from any New York State Agency (i.e. the Substance Abuse Prevention and Treatment Block Grant).

25. State Grants (Attach detail)

For each reported program, enter the anticipated New York State (NYS) Agency grant revenues expected for the reporting period. *Do not* include any revenues expected from one of the three (3) DMH State Agencies (OASAS, OMH and/or OMRDD) or the NYS Education Department (SED).

All of the following criteria must be met for the anticipated revenues reported on this line:

i. The revenues *must* be received *directly* from a non CFR NYS Agency; and

ii. The revenues *must* be a component of the program funded by the applicable DMH State Agency.

Note: The expenses associated with the revenues reported on this line *must* also be included in lines 5 through 10 of this schedule.

26. LTSE Income Total (OMH and OMRDD Only)

OASAS: Make no entry.

OMH: For each reported program, enter the anticipated Long Term Sheltered Employment revenue. The amount entered must be equal to the amount that will be included in the service providers fully executed contract.

OMRDD: For each reported program, enter the anticipated Long Term Sheltered Employment revenue. The amount entered must be equal to the amount that will be included in the service providers fully executed contract.

27. Food Stamps (OASAS Only)

OASAS: For each reported program, enter the anticipated food stamp revenue.

OMH: Make no entry.

OMRDD: Make no entry.

28. Net Deficit Funding (State & LGU Funding Only)

For CBRs only, make no entry on this line.

29. Other Revenue

For each reported program, enter all other anticipated revenues not reported on lines 14 through 28 above.

OASAS: Detail *must* be provided for any individual revenue item in excess of $1,000. The following types of revenue are *some, but not all,* of the types of revenue reported on this line for OASAS programs:

i. Disproportionate Share (DSH)

ii. Closely Allied Entities

iii. Voluntary Contributions

iv. TANF

v. Prior Year Revenue.

OMH: Detail *must* be provided for *all* revenue items regardless of the dollar amount. The following types of revenue are *some, but not all,* of the types of revenue reported on this line for OMH programs:

i. Non-Medicaid CRs Prior Years

ii. ICM Prior Years

iii. SCM Prior Years

iv. BCM Prior Years

v. ACT Prior Years

vi. Accrued Disproportionate Share (DSH) Revenue

vii. vii. Federal Salary Sharing (See Appendix V of this Manual and the CFR Manual for more information about OMH Federal Salary Sharing.)

viii. CSP Reserve Prior Years (See Appendix DD of this Manual and the CFR Manual for more information about CSP.)

ix. COPS Prior Years

x. Non-COPS Prior Years.

OMRDD: Detail *must* be provided for any individual revenue item in excess of $1,000.

30. Total Gross Revenues

For each reported program, enter the sum of lines 14 through 29.

GAAP Adjustments to Revenue

31. Participant Allowance

For each reported program, enter the anticipated total amount of the program participants' personal allowances, income disregards, and work related exemptions.

32. Uncollectible Accounts Receivable

Make no entry. Uncollectible Accounts Receivable is not an allowable adjustment to revenue for State Aid budgeting and claiming.

33. Other (Attach detail if greater than $1,000)

For each reported program, enter all other anticipated revenues not reported on lines 31 and 32 above.

OASAS: Detail *must* be provided for any individual revenue item in excess of $1,000.

OMH: Detail *must* be provided for *all* revenue items regardless of the dollar amount

OMRDD: Detail *must* be provided for any individual revenue item in excess of $1,000.

34. Total GAAP Adjustments

For each reported program, enter the sum of lines 31 through 33.

35. Net GAAP Revenues

For each reported program, enter the result of line 30 minus line 34.

NON-GAAP Adjustments to Revenue

36. Exempt Contract Income

For each applicable program, enter the anticipated exempt contract income for the reporting period. Exempt contract income is calculated by subtracting participant wages

and raw materials from total contract sales. Worksheets supporting the calculation of exempt contract income *must* be maintained by the service provider.

Calculation: Contract sales minus Participant Wages minus Raw Materials = Exempt Contract Income

Note: If non-consumer employees work on industrial contracts, the portion of the contract income attributable to these employees, their wages and the raw materials they use *cannot* be included in the exempt contract income calculation. Additionally, any of the resources above that are not attributable to industrial contracts (such as janitorial services for your agency) *cannot* be used in the exempt contract income calculation.

37. Exempt LTSE Income

For each applicable program, enter the anticipated exempt Long Term Sheltered Employment (LTSE) income for the reporting period. Exempt LTSE income is calculated by multiplying total LTSE income on line 26 by 40% (.40).

Calculation: Total LTSE Income x .40 = Exempt LTSE Income

38. Net Deficit Funding

For CBRs only, make no entry on this line.

39. Other (Attach detail if greater than $1,000)

For each reported program, enter all other anticipated revenues not reported on lines 14 through 28 above.

OASAS: Detail *must* be provided for any individual revenue item in excess of $1,000. The following types of revenue are *some, but not all,* of the types of revenue reported on this line for OASAS programs:

i. Not Applied Revenue

OMH: Detail *must* be provided for *all* revenue items regardless of the dollar amount. The following types of revenue are *some, but not all,* of the types of revenue reported on this line for OMH programs:

i. OMH Share Medicaid CR

ii. Provider Share Medicaid

iii. CSP Reserve

iv. COPS Reserve

v. ICM Current Year Exempt

vi. SCM Current Year Exempt

vii. BCM Current Year Exempt

viii. ACT Current Year Exempt

ix. Non-COPS Reserve

OMRDD: Detail *must* be provided for any individual revenue item in excess of $1,000.

40. Total Non-GAAP Adjustments

For each reported program, enter the sum of Lines 36 through 39.

41. Subtotal Adj. to Revenue

For each reported program, enter the sum Lines 34 and 40.

42. Total Net Revenues

For each reported program, enter the result of Line 30 minus 41.

43. Net Operating Cost

For each reported program, enter the result of Line 13 minus 42

Deficit Funding

Deficit funding consists of those funding sources (i.e. State, Local Government, Voluntary Contributions, Non-funded) used to offset the net operating costs. Since the overall budget/claim of an agency must balance, the net operating costs on line 43 must equal the total deficit funding on line 49.

44. State

For each reported program, enter the anticipated amount of State funds to be applied against the net operating cost on line 43. These State funds will partially or fully finance the net operating cost of the service provider. This includes any Federal pass through funds received from the funding DMH State Agency.

Note: *Please see "Percent of Net Costs" information at the end of this section.*

45. Local Government

For each reported program, enter the anticipated amount of local government (public) funds that will be used to finance the required match of State funds on line 44. Local government funds are funds raised by the county through a tax levy or some other means. *Do not* include the State or service provider share of the net deficit to be funded on this line.

OASAS: Only Local Government tax dollars which are considered maintenance of effort (MOE) should be reported on Line 45. All other local contributions (i.e., non-MOE, city, town, school district) should be shown under Revenue on Line 29 – Other.

46. Service Provider Share (Voluntary Contributions)

OASAS: Make no entry. All voluntary contributions *must* be reported on line 29, Other Revenue, pursuant to Article 26 of NYS Mental Hygiene Law.

OMH: For each reported program, enter the amount of voluntary contributions, if any, used to finance the required match of State funds. This amount may be stipulated in a local county contract or a direct contract with a funding DMH State Agency.

OMRDD: For each reported program, enter the amount of voluntary contributions, if any, used to finance the required match of State funds. This amount may be stipulated in a local county contract or a direct contract with a funding DMH State Agency.

47. Total Approved Deficit Funding

For each reported program, enter the total of lines 44 through 46. This amount represents the anticipated portion of program expenses less total revenue that will be approved for State Aid reimbursement by the funding DMH State Agencies.

48. Non-Funded

For each reported program, enter the anticipated amount of program expenses that will *not* be approved for State Aid reimbursement. This amount represents the difference between line 43 and line 47. Fiscal support for the expenses entered on line 48 is the sole responsibility of the service provider.

49. Total Net Deficit

For each reported program, enter the sum of lines 44 through 47.

Note: *Line 49 must equal line 43.*

Percent (%) of Net Costs

The amounts entered on line 44 of the DMH-2 are calculated by applying the percentages applicable for each funding source code used on the DMH-3 and then totaling all the results. Funding Source code information can be found in Appendix N of this manual and the CFR Manual.

Unified Services counties should use the applicable Unified Services Rate indicated below or the reimbursement rate for the funding source code if it is higher than the Unified Services Rate.

Unified Services Rates

County	*Disability*	*Percentage*
Rensselaer	OASAS, OMH and OMRDD	86.85%
Rockland	OASAS, OMH and OMRDD	69.50%
Warren	OASAS, OMH and OMRDD	87.10%
Washington	OASAS, OMH and OMRDD	96.99%
Westchester	OASAS, OMH and OMRDD	69.32%

Note: *In some cases, the surplus generated by a program(s) may be used to offset a deficit(s) generated by another program(s) funded by the same DMH Agency. Service providers should refer to the definition for In-contract/Out-of-contract in the glossary and Appendix Z for a policy statement and procedure.*

Service providers are not required to complete this schedule for their OMH funded programs.

The DMH-2A (Budget) schedule of the Consolidated Budget Report (CBR) is used to provide an itemized listing of the anticipated equipment assets service providers intend to purchase during the reporting period. Only those items of equipment included on line 9 of the DMH-2 (Budget) schedule are detailed on the DMH-2A (Budget). Do not include any minor expensed equipment items budgeted in other than personal service (OTPS) as minor expensed equipment.

The following guidelines should be followed in completing this schedule:

1. A separate DMH-2A (Budget) schedule *must* be prepared for the NYS Office of Alcoholism and Substance Abuse Services (OASAS) and/or NYS Office of Mental Retardation and Developmental Disabilities.

2. A separate OASAS and/or OMRDD DMH-2A (Budget) schedule *must* be prepared for each county in which the service provider operates programs and receives Aid to Localities (State Aid) funding. Aid to Localities funding may be provided directly through a contract with OASAS and/or OMRDD or indirectly through a contract with a Local Governmental Unit (LGU).

3. The programs reported on the DMH-2A (Budget) schedule *must* be arrayed in the same order they appear on schedules CBR-4, DMH-2 (Budget) and DMH-3 (Budget).

4. The *actual* costs of the equipment asset purchases should be indicated on this schedule, *not the depreciation value.*

5. This schedule *must b*e completed by all service providers budgeting expenses on line 9 of the DMH-2 (Budget) schedule.

6. The equipment items budgeted on this schedule should correspond only to those expenses on line 9 of the DMH-2 (Budget) schedule. *Do not* include any expensed equipment with a value of less than $1,000 or a useful life of less than two years if it was budgeted as part of OTPS.

7. All individual items of equipment costing over $2,500 each must be listed separately.

8. All multiple or bulk purchases of like items whose total aggregate cost is equal to or greater than $2,500 *must* be detailed as indicated in the examples below.

   Examples: 12 desks @ $250 each, or, 3 vans @ $15,000 each.

9. All miscellaneous individual items of equipment costing less than $2,500 each and not purchased in bulk can be aggregated into one total amount on line 23.

Heading Instructions

For the Period *

Enter the beginning and ending dates of the budget period covered by this document.

State Agency *

Indicate OASAS and/or OMRDD on State Agency specific schedules.

Agency Name *

Enter the name of the organization (service provider) operating the reported program(s).

Agency Code *

Enter the five (5) digit code assigned to the organization operating the reported program(s).

Column Number

For each program reported, assign a column number. Label programs in consistent column order within each funding DMH State Agency's schedules. Programs *must* be assigned the same column number throughout all schedules of the CBR. Additional programs must be assigned the next sequential column number on additional pages when necessary.

***** *Complete this at the top of each page of the DMH-2A (Budget).*

Line Instructions

1. *Program Type*

For each reported program, enter the type of program operated using the program names in Appendices E and G of this manual and the CFR Manual.

2. *Program Code & Program Code Index*

For each reported program, enter the applicable DMH State Agency program code and program code index. Please see Appendices E and G of this manual and the CFR Manual for complete listings of valid program codes. Program code indexes are assigned as follows:

OASAS:

i. Use the same array of program codes and indexes as were used during the prior reporting period unless programs have been combined, added or removed from OASAS funding for this reporting period. If programs have

been added or removed from OASAS funding, consult with the OASAS Field Office for the appropriate array of program codes and indexes to be used.

OMRDD:

i. OMRDD programs reported on a program type basis (expenses and revenues aggregated and reported in one (1) column) and programs codes 0053, 0054, 0090, 0091, 0200, 0202, 1090, 1091, 2090, 2091, 3090, 4090, 5090, 5091, 6090 and 6091 use index code "00". For all other OMRDD programs use "01" for the first occurrence of each program type, "02" for the second occurrence, "03" for the third occurrence, etc (e.g. Family Support).

3. *Equipment Greater than or Equal to $2,500.*

Enter the description of each individual item of equipment or bulk purchase greater than or equal to $2,500 as described in the guidelines indicated on the page 15.1

For each program reported, enter the dollar value of the equipment applicable to that program.

4. *Equipment Less than $2,500*

For each program reported, enter the total dollar value of all items of equipment costing less that $2,500 that are applicable to that program. This should be done consistent with the guidelines indicated on page 15.1.

5. *Total Equipment*

For each program reported, enter the sum lines 3 through 23.

Note: *If equipment purchases with a value of more than $1,000 and having a useful life of two (2) or more years are being expensed in the year of purchase (not depreciated) the number entered on line 24 of the DMH-2A (Budget) schedule must equal the number entered on line 9 of the DMH-2 (Budget) schedule submitted. However, line 24 of the DMH-2A (Budget) schedule will not equal line 9 of Schedule DMH-2 (Budget) schedule if line 9 of the DMH-2 (Budget) schedule also includes expenses relating to leased equipment.*

The DMH-3 (Budget) schedule of the Consolidated Budget Report (CBR) is used to display individual program expenses, revenues and net operating costs by funding source code for the program types and/or program sites and/or and contract for programs funded and/or certified by one (1) or more of the Department of Mental Hygiene (DMH) State Agencies. Please refer to Section 8 of the Consolidated Fiscal Reporting and Claiming Manual (CFR Manual) for more detailed information on program types and program sites.

The following guidelines should be followed in completing this schedule:

1. A separate DMH-3 (Budget) schedule must be prepared for each DMH State Agency from which the service provider receives Aid to Localities (State Aid) funding. Aid to Localities funding may be provided directly through a contract with a DMH State Agency or indirectly through a contract with the Local Governmental Unit (LGU).

2. A separate DMH-3 (Budget) schedule must be prepared for each county in which the service provider operates programs and receives Aid to Localities (State Aid) funding. Aid to Localities funding may be provided directly through a contract with a DMH State Agency or indirectly through a contract with the Local Governmental Unit (LGU).

3. The programs reported on the DMH-3 (Budget) schedule *must* be arrayed in the same order they appear on the CBR-4, DMH-2 (Budget) and DMH-2A (Budget) schedules.

Heading Instructions

For the Period *

Enter the beginning and ending dates of the budget period covered by this document.

State Agency *

Indicate the DMH State Agency(ies) that fund(s) and/or certify(ies) the reported programs.

Agency Name *

Enter the name of the organization (service provider) operating the reported program(s).

Agency Code *

Enter the five (5) digit code assigned to the organization operating the reported program(s).

Date Prepared *

Enter the date the DMH-3 (Budget) schedule was prepared.

** Complete this at the top of each page of the DMH-3.*

County Name and Code *

Enter the name and associated code of the county where the budgeted services will be provided and/or funded through a local contract or a direct contract with a DMH State Agency. Please see Appendix C of this manual and the Consolidated Fiscal Reporting and Claiming Manual (CFR Manual) for a list of New York State counties and their associated county codes.

OMH Note: *Service providers located in the five (5) boroughs of the City of New York (Bronx, Kings, New York, Queens and Richmond) should use the county name "New York" and the county code "31" for all reported programs.*

Prepared by *

Enter name of person that prepared the CBR and can answer questions about the information contained in the document.

Telephone *

Enter the preparer's telephone number.

Column Number

For each program reported, assign a column number. Label programs in consistent column order within each funding DMH State Agency's schedules. Programs *must* be assigned the same column number throughout all schedules of the CBR. Additional programs must be assigned the next sequential column number on additional pages when necessary.

Note: *Approved Consolidated Fiscal Reporting System (CFRS) software automatically assigns and organizes column numbers.*

Line Instructions

1. *Accounting Method*

For each reported program, enter the method of accounting used i.e., accrual, modified accrual or cash. Please refer to Section 3.0 of this manual for more information on accounting methods.

2. *Program Type*

For each reported program, enter the type of program operated using the program

names in Appendices E, F and G of this manual and the CFR Manual.

** Complete this at the top of each page of the DMH-3.*

3. *Program Code & Program Code Index*

For each reported program, enter the applicable DMH State Agency program code and program code index. Please see Appendices E, F and G of this manual and the CFR Manual for complete listings of valid program codes. Program code indexes are assigned as follows:

OASAS:

i. Use the same array of program codes and indexes as were used during the prior reporting period unless programs have been combined, added or removed from OASAS funding for this reporting period. If programs have been added or removed from OASAS funding, consult with the OASAS Field Office for the appropriate array of program codes and indexes to be used.

OMH:

i. Use the same array of program codes and indexes as were used during the prior reporting period unless programs have been added or removed from OMH funding for this reporting period. If programs have been added or removed from OMH funding, consult with the OMH Field Office for the appropriate array of program codes and indexes to be used.

ii. For OMH Community Residences, each supervised site, each MI/MR site and each Children and Youth site is considered a program and must be reported in a separate column.

iii. For OMH start up program and PDG program codes and indexes, see Appendix F of this manual and the CFR Manual.

OMRDD:

i. OMRDD programs reported on a program type basis (expenses and revenues aggregated and reported in one (1) column) and programs codes 0053, 0054, 0090, 0091, 0200, 0202, 1090, 1091, 2090, 2091, 3090, 4090, 5090, 5091, 6090 and 6091 use index code “00”. For all other OMRDD programs use “01” for the first occurrence of each program type, “02” for the second occurrence, “03” for the third occurrence, etc (e.g. Family Support).

4. *Total Persons Served/Month*

For each reported program, enter the anticipated average number of persons to be served on a monthly basis.

5. *Total Units of Services*

For each reported program, enter the anticipated units of service to be provided during this reporting period.

Note: Budgeting and claiming of units of services may not be applicable to some programs. Please see Appendices E through G for more information on units of service applicability.

6. *Gross Cost/Unit of Service*

For each applicable program, divide the amount reported on line 13 of the DMH-2 (Budget) schedule by the total units of service reported on line 5.

7. *Net Cost/Unit of Service*

For each applicable program, divide the amount reported on line 43 of the DMH-2 (Budget) schedule, by the total units of service reported on line 5.

8. *Please check:*

OASAS: Make no entry.

OMH: Make no entry.

OMRDD: Indicate if the revenue reported in the funding sources is on a non-participant specific basis or a participant specific basis. Use the following guidelines:

The methodology for the allocation of revenue categories varies as follows:

- *Non-participant Specific Revenue:* Allocates revenues to State agencies based on the percentage of units of service provided to each State agency. The revenues reported on the DMH-2 (Budget) schedule must be designated as appropriate for each program. In order to allocate revenues for the same program by State agency, the percentage of the Total Units of Service indicated at the top of the Schedule DMH-3 must be used. For example, if 35% of the total units of service are for an OMRDD Workshop, then 35% of the gross expenditures, revenue and net

operating cost are allocated to the NYS Office of Mental Retardation and Developmental Disabilities.

This methodology also applies when allocating among funding sources within the same program for one disability. The only exception to this methodology would be a funding source within that program which requires a separate site and separate records.

- *Participant Specific Revenue:* Allocates revenues on a program participant specific basis by funding source. Service providers using this methodology must maintain records supporting the allocations to funding sources. The revenues reported on the DMH-2 (Budget) schedule must be allocated for each program by funding source. Participant specific revenue includes all of the revenue categories that are specific to program participants. Allocating these revenues involves an accurate recording of revenues received. Also, this process automatically classifies revenues by State Agency. Gross expenditures must be allocated using units of service for each funding source. The participant specific revenue is then applied to each funding source as recorded in the service provider's ledger.

Funding Source Code (s) - Blocks A - C:

State Aid reimbursement for each reported program will come from one (1) or more funding source codes and/or indexes. Different funding source codes and indexes cannot be commingled. Within each funding source code block, the funding source code/index (lines 9, 16 and 23), number of persons served/month (lines 10, 17 and 24), number of units of service (lines 11, 18 and 25), total adjusted expenses (lines 12, 19 and 26), less applied net revenue (lines 13, 20 and 27), net operating costs (lines 14, 21 and 28) and contract number (lines 15, 22 and 29) should be entered in accordance with the following instructions:

Funding Source Code/Index

For each program reported, enter the applicable three (3) digit numeric funding source code(s) to be used for the reimbursement of Aid to Localities (State Aid) funding. Please see Appendix N of this manual and the CFR Manual for a listing of valid funding source codes and their associated reimbursement rates.

Where applicable, the associated funding source code index should be entered as follows:

OASAS: For each reported program, enter the applicable alphabetic funding source index in the box to the right of the three digit numeric funding source code on lines 9, 16 and/or 23. The funding source code(s) and indexes used should be

consistent with the service provider's most recently approved budget as indicated on the county LGU Funding Authorization (Approval Letter) or Appendix B of OASAS direct contracts. Valid OASAS funding source code indexes are F, O, S, C or P. OASAS Funding source code indexes are defined in Appendix N of this manual and the CFR Manual.

OMH: OMH funded service providers must index funding source codes as listed in Appendix N of this manual. Enter this letter in the box to the right of the funding source codes, lines 9, 16, 23.

OMRDD: Make no entry.

Funding source codes indicated in each funding block of the DMH-3 (Budget) schedule must be consistent across the page for each funding block.

Non-funded Expenses

The last funding source block before totaling the program column will be used for non-funded amounts (funding source code 090). The difference between program total adjusted expenses, applied revenue and net operating costs and the adjusted expenses, applied revenue and net operating cost eligible for Aid to Localities reimbursement (including direct contracts) is the non-funded amount. Number of Persons Served and Units of Service should not be entered for this non-funded block.

OMH Note: *Please refer to Appendix Z – In Contract-Out of Contract for additional instructions.*

Line Instructions

Number Persons Served/Month (lines 10, 17 and 24)

Enter the anticipated average number of persons to be served on a monthly basis.

Number Units of Service (line 11, 18, 25)

For each applicable program, enter the anticipated units of service associated with each individual funding source code and/or index.

Note: Not all programs generate units of service. Please check the appropriate DMH State Agency's program code appendix in this manual for program code definitions and units of service applicability.

Total Adjusted Expenses (line 12, 19, 26)

For each unique funding source code and index in a program, enter the applicable portion of Total Adjusted Expenses from line 13 of the DMH-2 (Budget) schedule.

Less Applied Net Revenue (line 13, 20, 27)

For each unique funding source code and index in a program, enter the applicable allocated portion of Total Net Revenues from the DMH-2 (Budget) schedule.

Net Operating Costs (line 14, 21, 28)

For each unique funding source code and index in a program, enter the applicable allocated portion of Net Operating Costs from line 43 of the DMH-2 (Budget) schedule.

Contract Number (line 15, 22, 29)

For each unique funding source code and index in a program, enter the contract number as follows:

State Contract Number: For direct contracts with a funding DMH State Agency, enter the State Contract Number.

LGU Contract Number: For local county contracts, enter the LGU Contract Number if applicable. A contract number *must* be entered. If there is no county contract number assigned to the program enter the applicable county name or county abbreviation (up to 7 characters).

OASAS Note: The contract number used for each unique funding source code and index in a program on a DMH-3 (Budget) schedule ***must*** *match the contract number used for that program on line 2 of the DMH-2 (Budget) schedule. No contract number is required for funding source code 090.*

OMH Note: The contract number used in each column (Unique program code + program code index) of the DMH-3 (Budget) schedule should consist of a single State direct contract number or an appropriate local contract number. Direct and local contract numbers cannot be used in a single column on the DMH-3 (Budget) schedule.

OMRDD Note: There may be both direct contract numbers and local contract numbers in the same column (program code) of the DMH-3 (Budget) schedule. Each funding source code may have a unique contract number. At least one (1) contract number and associated type of contract (State or local) must match the contract number and

type of contract in the same column (program code) of the DMH-2 (Budget) schedule.

Block D - Totals from A-C Above:

30. ***Total Adjusted Expenses***

For each reported program, enter the sum of the Total Adjusted Expenses line for each unique funding source code and index used. This amount *must* match line 13 of the DMH-2 (Budget) schedule. If more than three (3) unique funding code and funding code index combinations are used, enter this total on the last DMH-3 (Budget) continuation sheet used. *Do not* enter page subtotals on any DMH-3 (Budget) continuation schedule other than the last one used.

31. ***Less Net Revenue***

For each reported program, enter the sum of the Less Applied Net Revenue line for each unique funding code and funding code index combination used. This amount *must* match line 42 of the DMH-2 (Budget) schedule. If more than three (3) unique funding code and funding code index combinations are used, enter this total on the last DMH-3 (Budget) continuation sheet. *Do not* enter page subtotals on any DMH-3 (Budget) continuation schedule other than the last one used.

32. ***Net Operating Costs***

For each reported program, enter the sum of the Net Operating Costs line for each unique funding source code and index used. This amount *must* match line 43 of the DMH-2 (Budget) schedule. If more than three (3) unique funding code and funding code index combinations are used, enter this total on the last DMH-3 (Budget) continuation sheet. *Do not* enter page subtotals on any DMH-3 (Budget) continuation schedule other than the last one used.

Total Column

Enter the sum of amounts listed in all columns going across the page for *each* unique funding code and funding code index combination. If more than five (5) unique program code and program code index combinations are used, enter this total on the last DMH-3 (Budget) continuation sheet. *Do not* enter funding code and funding code index combination subtotals on any DMH-3 (Budget) continuation schedule other than the last one used.

An integral component of the Consolidated Fiscal Reporting System (CFRS) is the claiming process for programs financed through Aid to Localities (State Aid) funding. The instructions contained in the following sections of this manual detail the procedures not-for-profit and county operated service providers should follow when completing intra-year and final, year-end claiming forms. Intra-year claims may be required quarterly or at mid-year at the discretion of the funding Department of Mental Hygiene (DMH) State Agencies or the LGU if the service provider is funded through a local contract.

Provision of State Aid

The DMH State Agencies are authorized to provide financial support for local services in Articles 25, 26 and 41 of New York State Mental Hygiene Law.

State Aid funding can be provided two (2) different ways:

1. LGUs, county operated programs, and not-for-profit service providers can receive State Aid funding through the Approval Letter process. State Aid Approval Letters are issued to an LGU by a DMH State Agency and provide the LGU with their authorized funding allocation for a specific fiscal reporting period. These Approval Letters have the same effect of law as fully executed legal contracts. Each DMH State Agency's Approval Letter displays their authorized State Aid allocation differently.

2. Not-for-profit service providers and governmental entities can also receive State Aid funding through a fully executed direct contract between the service provider and a DMH State Agency.

These sections of the manual only apply to service providers receiving State Aid through the State Aid Approval Letter process or through a direct contract with a DMH State Agency. Service providers meeting one or more of the following criteria are *not* required to complete State Aid claiming documents:

- Service providers funded completely by cost-based rates or fees,
- For-profit (proprietary) service providers operating certified OASAS, OMH and/or OMRDD programs.

Differences between Cost Reporting and State Aid Claiming

Cost reporting to DMH State Agencies is accomplished using the core schedules of the year-end Consolidated Fiscal Report (CFR). The CFR core schedules are CFR1, CFR-2, CFR-3, CFR-4, CFR-4A, CFR-5, CFR-6 and DMH-1. These schedules are completed using full accrual accounting; major equipment and property assets are depreciated; and agency administration expenses are distributed to all of a service provider's funding sources and programs using the ratio value allocation methodology.

State Aid claiming is accomplished using intra-year claim schedules (CQR-1s) and the CFR-i, CFR-iii, DMH-2, DMH-2A and DMH-3 claiming schedules of the Consolidated Claim Report (CCR) that is included as part of a complete CFR submission. State Aid claiming schedules may

be completed using accrual, modified accrual or cash accounting and major equipment assets may be completely expensed in the year of purchase. Additionally, the total agency administration expenses allocated to OASAS and OMH using the ratio value methodology may be redistributed between programs within the OASAS and OMH schedules using an allocation methodology other than ratio value (OMRDD funded service providers must use ratio value on their claiming schedules as well as on their CFR core schedules).

For all funding DMH State Agencies, the method of accounting, the method of reporting major equipment assets (depreciating or expensing), and the agency administration allocation methodologies used *must* be identical to those utilized in the preparation of the service provider's approved budget. Any change to a service provider's method of accounting, reporting of major equipment assets and/or agency administration allocation methodology *must* be approved in advance by the funding DMH State Agency(ies) and LGU (if funded through a local county contract).

Programs Funded by More Than One (1) DMH State Agency and/or LGU

Service providers may operate programs funded by more than one (1) DMH State Agency and/or more than one (1) LGU. Service providers may also operate shared programs. Shared programs are a single program that is funded by two (2) or more DMH State Agencies. State Aid claiming schedules for these three types of funding are completed using the following instructions:

Number of DMH State Agencies	DMH State Agency Funding		Number of Funding LGUs	Reporting Requirement
	Individual	Shared		
1	X		1	DMH State Agency specific schedules for the funding LGU
1	X		>1	DMH State Agency specific schedules for each funding LGU
>1	X		1	Sets of DMH State Agency specific schedules for the funding LGU
>1		X	1	The shared program expenses are allocated between the DMH State Agencies and separate DMH State Agency specific schedules are prepared for the funding LGU.
>1	X		>1	Sets of DMH State Agency specific schedules for each funding LGU
>1		X	>1	The shared program expenses are allocated between the DMH State Agencies and separate DMH State Agency specific schedules are prepared for each funding LGU.

Expenses, revenues and net operating costs should be allocated between LGUs and/or DMH State Agencies using units of service or New York State approved percentages, whichever is

appropriate. Service providers should verify the allocation methodology to be used with the funding DMH State Agency(ies) and or LGU(s).

LGU Administration Expenses (Program Code 0890)

LGU administration expenses (program 0890) include those expenses necessary to carry out the duties and responsibilities outlined in Article 41 of the Mental Hygiene Law (MHL). Administrative expenses related to the duties and responsibilities in MHL Article 41.47 are *not* to be included in the LGU administration expenses reported in program code 0890. Administrative expenses pertaining to MHL Article 41.47 should be reported in program code 0870, Monitoring and Evaluation (CSS). Agency administration expenses for county operated programs should *not* be included in program code 0890, LGU administration or program code 0870, Monitoring and Evaluation (CSS). Agency administration expenses for county operated programs should be reported on the agency administration line of all non-0890/0870 programs using the appropriate allocation methodology.

For budgeting and claiming purposes, LGUs *must* use the approved percentage splits for LGU Administration expenses established in 1988. See Appendix K of this manual and the CFR Manual for a listing of the approved 1988 percentages.

***Note**:* *LGUs cannot allocate indirect costs following the guidelines issued by the Federal Office of Management and Budget (OMB) in their circular 74-4. New York State policy regarding OMB Circular 74-4 can be found in The New York State Accounting System User Procedures Manual in Section 6.0400 – Special Payments – Municipal Overhead Costs.*

Additional information regarding LGU administration expenses as well as the text of Section 6.0400 of The New York State Accounting System User Procedures Manual can be found in Section K of this manual and the CFR Manual.

General State Aid Claiming Requirements

Supporting worksheets used to complete State Aid claiming schedules may be requested by the funding DMH State agency at its discretion. LGUs and/or DMH State Agency Field Offices and Regional Offices may establish additional requirements for the preparation and submission of State Aid claims as long as these requirements do not conflict with instructions contained in this manual and the CFR Manual.

It is the LGU's responsibility to ensure that county operated service providers and local contract funded not-for-profit service providers are aware of and understand the DMH State Agency requirements published in this manual and the CFR Manual. It is also the LGU's responsibility to ensure that these service providers are aware of and understand any additional LGU-specific requirements.

The instructions contained in this section of the Consolidated Budget and Claiming (CBR) Manual describe Local Governmental Unit (LGU) and direct contract service provider responsibilities associated with the preparation and submission of intra-year mid-year and final State Aid claims to the Office of Alcoholism Abuse and Substance Abuse Services (OASAS).

The specific instructions provided are broken into two main (2) sections:

- Instructions specific to LGU preparation and submission of intra-year and final State Aid claims; and
- Instruction specific to direct contract service provider preparation and submission of intra-year and final State Aid claims.

OASAS LGU General Instructions

For each fiscal reporting period, LGUs are required to submit two (2) State Aid claim packages to OASAS. The first is the mid-year claim package covering the first six (6) months of the fiscal reporting period. The second is the final claim package covering the complete 12 month fiscal reporting period.

Intra-year claims are completed on the Agency Quarterly Fiscal Summary (CQR-1). Final claims consist of the Consolidated Claim Report (CCR). The OASAS CCR is comprised of the CFR-i, CFR-iii, DMH-2, DMH-2A and DMH-3 of the year-end Consolidated Fiscal Report (CFR).

Instructions for completing CQR-1s are included in this manual. Instructions for completing and submitting CFRs and CCRs are described in the Consolidated Fiscal Reporting and Claiming (CFR) Manual. LGUs should ensure that all county operated and not-for-profit service providers complete and submit their CFRs and associated CFR-i, CFR-iii, DMH-2, DMH-2A and DMH-3 claim schedules in accordance with the instructions provided in the CFR Manual issued for the correct fiscal reporting period.

For each fiscal reporting period, LGUs are expected to ensure that all county operated and not-for-profit service providers funded and/or certified to provide mental health services in the county have used approved Consolidated Fiscal Reporting System (CFRS) software to complete and electronically submit their Claiming documents. Please see section 4.0 of this manual and Section 5.0 of the CFR Manual for more information regarding CFRS software.

Both of the required LGU claim packages include schedules for the LGU as well as OASAS funded county operated and not-for profit providers of chemical dependence services.

“Revised” State Aid claims should be submitted in the following instances:

- To correct erroneous intra-year or final claim schedules submitted to OASAS.
- To submit additional intra-year claim schedules for service providers that were delinquent in reporting and were not included in the original intra-year claim package submitted to OASAS.

OASAS reserves the right to reject and return all or part of any State Aid claim package that does not comply with the procedures and policies outlined in this manual and/or any other expressed instructions, policies and/or procedures set forth by OASAS.

OASAS LGU Submission Requirements

In addition to the electronic submission, OASAS currently requires that LGUs submit paper copies of intra-year and final State Aid claim packages to the following address:

NYS Office of Alcoholism and Substance Abuse Services
Bureau of Financial Management
1450 Western Avenue
Albany, NY 12203-3526

At their discretion, OASAS Field Offices may require that LGUs send them copies of all intra-year and/or final claim packages submitted. Please check with your Field Office Program Representative for more information on their specific policies in this area.

OASAS LGU Due Dates

LGUs State Aid claims are due for submission by the following dates:

Submission	Counties	NYC LGU *
Mid-Year Claim	August 15th	February 15th
Final Claim	May 1st	November 1st

* The NYC LGU is the NYC Department of Health and Mental Hygiene (NYC DOHMH)

OASAS LGU Intra-year Claims

OASAS intra-year LGU State Aid claim packages consist of the following documents:

Counties

- LGU Fiscal Summary (CQR-3)
- Agency Quarterly Fiscal Summaries (CQR-1s) for each county operated and not-for-profit service provider receiving State Aid through the LGU

NYC DOHMH

- NYC Quarterly Fiscal Summary (CQR-2)
- Agency Quarterly Fiscal Summaries (CQR-1s) for each NYC operated and not-for-profit service provider receiving State Aid through the NYC DOHMH

To the extent possible, submission of OASAS intra-year State Aid claims should not be delayed beyond the submission due date because one or more county operated or not-for-profit service

providers have not submitted CQR-1s to the LGU. Once received, the delinquent CQR-1s should be submitted as a supplemental State Aid claim.

Instructions for completing CQR-1s, CQR-2s and CQR-3s can be found elsewhere in this manual.

OASAS LGU Final Claims

OASAS final LGU State Aid claim packages consist of the following documents:

Counties

- LGU Fiscal Summary (CQR-3)
- Consolidated Claim Reports (CCRs) for each county operated and not-for-profit service provider receiving State Aid through the LGU

NYC DOHMH

- NYC Quarterly Fiscal Summary (CQR-2)
- Consolidated Claim Reports (CCRs) for each county operated and not-for-profit service provider receiving State Aid through the NYC DOHMH

CCRs for both non-NYC LGUs and the NYC DOHMH consist of the CFR-i, CFR-iii, DMH-2, DMH-2A and DMH-3 schedules of the year-end CFR.

Note: *Incomplete final claim packages will not be accepted or processed.*

In the event that one or more county operated or not-for-profit service provider's CFR has not been completed or finalized in time for the LGU to meet the submission due date, the LGU should not delay in submitting the claim to OASAS. Instead, preliminary ("estimated") CCRs (CFR-i, CFR-iii, DMH-2 and DMH-3) should be submitted for the delinquent service providers.

If preliminary ("estimated") claim schedules are submitted to OASAS the LGU *must* ensure that it:

1. receives copies of the delinquent service provider's(s') final claim schedules derived from their completed and finalized CFR(s); and,

2. submits a revised final claim package to OASAS that includes the replacement final claim schedules *and* a revised CQR-3 incorporating any changes necessitated by those new final claim schedules.

OASAS will consider the fiscal information submitted on any service provider's preliminary ("estimated") claim schedules to be final if final claim schedules derived from the affected service provider's(s') completed CFR(s) are not submitted to OASAS within 60 days of the final claim submission due date (May 1st for the January - December fiscal reporting period and

November 1st for the July - June fiscal reporting period).

All requests for budget changes must be submitted to the appropriate OASAS Field Office with sufficient time for OASAS review and approval by August 1st for January - December claims and March 1st for July - June claims.

Late submissions that require an additional State aid payment to the LGU may not be honored or processed after the September 15th lapse date of State appropriations.

OASAS Direct Contract Service Provider General Instructions

For each fiscal reporting period, OASAS direct contract funded service providers are required to submit intra-year and final State Aid claim packages.

The standard intra-year State Aid claim is the mid-year claim covering the first six (6) months of the fiscal reporting period. However, at its discretion, OASAS may require direct contract service providers to submit three (3) quarterly State Aid claim packages. Intra-year claims are completed on the Agency Quarterly Fiscal Summary (CQR-1).

The final State Aid claim package covers the complete 12 month fiscal reporting period. Final claims consist of the Consolidated Claim Report (CCR). The CCR is comprised of the CFR-iii, DMH-2, DMH-2A and DMH-3 of the year-end Consolidated Fiscal Report (CFR).

Instructions for completing CQR-1s are included in this manual. Instructions for completing and submitting CFRs are described in the Consolidated Fiscal Reporting and Claiming (CFR) Manual.

For each fiscal reporting period, contractors are expected to use approved Consolidated Fiscal Reporting System (CFRS) software to complete and electronically submit their Claiming Documents. Please see section 4.0 of this manual and Section 5.0 of the CFR Manual for more information regarding CFRS software.

“Revised” State Aid claims should be submitted in the following instances:

- To correct erroneous intra-year claim schedules that were previously submitted to OASAS.
- To correct erroneous DMH-2, DMH-2A and/or DMH-3 claim schedules that were previously submitted to OASAS.

OASAS reserves the right to reject and return all or part of any State Aid claim package that does not comply with the procedures and policies outlined in this manual and/or any other expressed instructions, policies and/or procedures set forth by OASAS.

OASAS Direct Contract Service Provider Submission Requirements

In addition to the electronic submission, OASAS currently, requires that direct contract service

providers submit paper copies of mid-year, quarterly (if required) and final State Aid claim packages to the following address:

NYS Office of Alcoholism and Substance Abuse Services
Bureau of Financial Management
1450 Western Avenue
Albany, NY 12203-3526

At their discretion, OASAS Field Offices may require that direct contract funded service providers send them copies of all intra-year and/or final claim packages submitted. Please check with your OASAS Field Office Representative for more information on their specific policies in this area.

OASAS Direct Contract Service Provider Due Dates

OASAS direct contract service providers State Aid claims are due for submission by the following dates:

Submission	Counties Service Providers	NYC Service Providers
Quarterly Claim (if required)	1st Quarter: May 15th 2nd Quarter: August 15th 3rd Quarter: November 15th	1st Quarter: November 15th 2nd Quarter: February 15th 3rd Quarter: May 15th
Mid-Year Claim	August 15th	February 15th
Final Claim	May 1st	November 1st

Due dates for OASAS direct contract service providers funded on a period other than January to December or July to June should submit mid-year, quarterly (if required) and final claims as follows:

Mid-Year Claims: 45 days after the end of the first six months of the twelve month contract period.

Quarterly Claims: 45 days after the last day of each three month period of the 12 month contract period.

Final Claims: 120 days after the end of the twelve month contract period.

OASAS Direct Contract Service Provider Intra-year Claims (Mid-year/Quarterly)

Intra-year claims for OASAS direct contract service providers consist of the following documents:

Quarterly Claims (if required)

- Agency Quarterly Fiscal Summary (CQR-1)

Mid-Year Claims

- Agency Quarterly Fiscal Summary (CQR-1)

OASAS Direct Contract Service Provider Final Claims

The OASAS direct contract service provider final State Aid claim package consists of the following documents:

- State Aid Voucher (AC-1171)
- CFR-i, Agency Identification and Certification Statement
- CFR-iii, County/NYC Certification Statement
- DMH-2, Aid to Localities/Direct Contract Summary
- DMH-2A, Aid to Localities/Direct Contract Equipment Summary
- DMH-3, Aid to Localities and Direct Contracts Program Funding Source Summary

OASAS direct contract service providers will prepare a final State Aid Voucher (AC-1171) in accordance with the instructions in this manual and will have it signed by the Executive Director or the designee.

Note: *In the event that the CFR has not been completed in time to meet the direct contract submission due date, service providers should not delay in submitting this claim. Instead, preliminary ("estimated") claim schedules should be submitted by the submission date.*

In any instance where preliminary ("estimated") claim schedules have been submitted, service providers must forward the final claim schedules derived from the completed CFR as soon as they are available. The CFR derived schedules will then be used to replace the preliminary schedules already processed.

Late submissions that require an additional State aid payment to the direct contract service provider may not be honored or processed after the September 15th lapse date of State appropriations.

The instructions contained in this section of the Consolidated Budget and Claiming Report. (CBR) Manual describe Local Governmental Unit (LGU) and direct contract service provider responsibilities associated with the preparation and submission of final State Aid claims to the Office of Mental Health (OMH).

Note: *OMH does not require the submission of intra-year (mid-year or quarterly) State Aid claims. Only the final year end claim is required for submission.*

The specific instructions provided are broken into two main (2) sections:

- Instructions specific to LGU preparation and submission of final State Aid claims; and
- Instruction specific to direct contract service provider preparation and submission of final State Aid claims.

OMH LGU General Instructions

For each fiscal reporting period, LGUs are required to ensure that all county operated and not-for-profit service providers funded and/or certified to provide mental health services in the county prepare a final Consolidated Claim Report (CCR). The CCR for OMH consists of the DMH-2 and DMH-3 claiming schedules included in each service provider's completed Consolidated Fiscal Report (CFR).

Instructions for completing and submitting CFRs are described in the CFR Manual. LGUs should ensure that all county operated and not-for-profit service providers complete and submit their CFRs and associated DMH-2 and DMH-3 claim schedules in accordance with the instructions provided in the CFR Manual issued for the correct fiscal reporting period.

For each fiscal reporting period, LGUs are required to ensure that all county operated and not-for-profit service providers funded and/or certified to provide mental health services in the county have used approved Consolidated Fiscal Reporting System (CFRS) software to complete and electronically submit their CCRs. Please see section 4.0 of this manual and Section 5.0 of the CFR Manual for more information regarding CFRS software.

For each fiscal reporting period, LGUs are required to ensure that all county operated and not-for-profit service providers funded and/or certified to provide mental health services in the county electronically submit "Revised" CCRs to correct erroneous claim schedules that have already been submitted to OMH.

OMH reserves the right to reject any CCR that does not comply with the procedures and policies outlined in this manual and/or any other expressed instructions, policies and/or procedures set forth by OMH.

OMH LGU Submission Requirements

OMH does not require the paper submission of a final claim package. LGUs are required to access, review and sign-off on county operated and not-for-profit service providers' CCRs using the OMH Aid to Localities Financial System (ALFS). Instructions for this process are included in Aid to Localities Spending Plan Guidelines and the ALFS Users Manual.

OMH LGU Due Dates

LGUs should ensure that county operated and not-for-profit service providers have electronically submitted their CCRs by the following dates:

	Non-NYC LGUs	**NYC LGU ***
Without 30 Day Extension	May 1st	November 1st
With 30 Day Extension	June 1st	December 1st

* The NYC LGU is the NYC Department of Health and Mental Hygiene (NYC DOHMH)

LGUs are required to have reviewed and electronically signed-off on all county operated and not-for-profit service providers' CCRs by the following dates:

	Non-NYC LGUs	**NYC LGU ***
Without 30 Day Extension	May 15st	November 15st
With 30 Day Extension	June 15st	December 15st

* The NYC LGU is the NYC Department of Health and Mental Hygiene (NYC DOHMH)

Late submissions that require an additional State aid payment to the LGU may not be honored or processed given State appropriation lapse deadlines.

OMH Direct Contract Service Provider General Instructions

For each fiscal reporting period, OMH direct contract funded service providers are required to prepare a final Consolidated Claim Report (CCR). The CCR for OMH consists of the DMH-2 and DMH-3 claiming schedules included in the service provider's completed Consolidated Fiscal Report (CFR).

Instructions for completing and submitting CFRs are described in the CFR Manual. Service providers should ensure that their CFRs and associated DMH-2 and DMH-3 claim schedules are prepared in accordance with the instructions provided in the CFR Manual issued for the correct fiscal reporting period.

For each fiscal reporting period, service providers are required to use approved Consolidated Fiscal Reporting System (CFRS) software to complete and electronically submit their CCRs. Please see section 4.0 of this manual and Section 5.0 of the CFR Manual for more information regarding CFRS software.

For each fiscal reporting period, service providers are required to electronically submit "Revised" CCRs to correct erroneous claim schedules that have already been submitted to OMH.

OMH reserves the right to reject any CCR that does not comply with the procedures and policies outlined in this manual and/or any other expressed instructions, policies and/or procedures set forth by OMH.

OMH Direct Contract Service Provider Due Dates

OMH direct contract service providers are required to have electronically submitted their CCRs by the following dates:

	Non-NYC Service Providers	**NYC Service Providers**
Without 30 Day Extension	May 1st	November 1st
With 30 Day Extension	June 1st	December 1st

Due dates for OMH direct contract service providers funded on a period other than January to December or July to June should submit CCRs as follows:

Without 30 Day Extension	120 days after the end of the twelve month contract period
With 30 Day Extension	150 days after the end of the twelve month contract period

Late submissions that require an additional State aid payment to the LGU may not be honored or processed given State appropriation lapse deadlines.

The instructions contained in this section of the Consolidated Budget and Claiming (CBR) Manual describe Local Governmental Unit (LGU) and direct contract service provider responsibilities associated with the preparation and submission of intra-year, mid-year and final State Aid claims to the Office of Mental Retardation and Developmental Disabilities (OMRDD).

The specific instructions provided are broken into two main (2) sections:

- Instructions specific to LGU preparation and submission of intra-year and final State Aid claims; and
- Instruction specific to direct contract service provider preparation and submission of intra-year and final State Aid claims.

OMRDD LGU General Instructions

For each fiscal reporting period, LGUs are required to submit two (2) State Aid claim packages to OMRDD. The first is the mid-year claim package that covers the first six (6) months of the fiscal reporting period. The second is the final claim package covering the complete 12 month fiscal reporting period.

Mid-year claims consist of CFR-i schedules and Agency Quarterly Fiscal Summaries (CQR-1s). Final claims consist of the Consolidated Claim Report (CCR). The CCR is comprised of the CFR-i, CFR-iii, DMH-2, DMH-2A and DMH-3 of the year-end Consolidated Fiscal Report (CFR).

Instructions for completing CQR-1s are included in this manual. Instructions for completing and submitting CFRs are described in the Consolidated Fiscal Reporting and Claiming (CFR) Manual. LGUs should ensure that all county operated and not-for-profit service providers complete and submit their CFRs and associated CFR-i, CFR-iii, DMH-2, DMH-2A and DMH-3 claim schedules in accordance with the instructions provided in the CFR Manual issued for the correct fiscal reporting period.

Both of the required LGU claim packages include schedules for the LGU as well as OMRDD funded county operated and not-for profit providers.

“Revised” State aid claims should be submitted in the following instances:

- To correct erroneous mid-year or final claim schedules that have already been submitted to OMRDD.
- To submit additional mid-year claim schedules for service providers that were delinquent in reporting and were not included in the original mid-year claim package submitted to OMRDD.

LGUs that *do not* have any service providers receiving Chapter 620 State Aid should submit, only one (1) State Aid voucher (AC-1171) with the mid-year or final State Aid claim submissions

LGUs that *do* have service providers receiving Chapter 620 State Aid must submit two (2) State Aid Vouchers, one for Local Assistance funding and one for Chapter 620 funding.

OMRDD reserves the right to reject and return all or part of any State Aid claim package that does not comply with the procedures and policies outlined in this manual and/or any other expressed instructions, policies and/or procedures set forth by OMRDD.

OMRDD LGU Submission Requirements

OMRDD currently, requires that LGUs submit paper copies of mid-year and final State Aid claim packages to the following address:

Claims Management Unit
NYS Office of Mental Retardation and Developmental Disabilities
44 Holland Avenue – 3rd Floor
Albany, NY 12229

At their discretion, OMRDD DDSOs and Regional Offices may require that LGUs send them copies of all mid-year and/or final claim packages submitted. Please check with your DDSO or Regional Office representative for more information on their specific policies in this area.

OMRDD LGU Due Dates

LGUs State Aid claims are due for submission by the following dates:

Submission	Non-NYC LGUs	NYC LGU *
Mid-Year Claim	August 15th	February 15th
Final Claim	May 15st	November 15st

* The NYC LGU is the NYC Department of Health and Mental Hygiene (NYC DOHMH)

OMRDD LGU Mid-year Claims

OMRDD mid-year LGU State Aid claim packages consist of the following documents:

Non-NYC LGUs

- State Aid Voucher(s) (AC-1171)
- LGU Fiscal Summary (CQR-3)
- CFR-i's and Agency Quarterly Fiscal Summaries (CQR-1s) for each county operated and not-for-profit service provider receiving State Aid through the LGU

NYC DOHMH

- State Aid Voucher(s) (AC-1171)
- NYC Quarterly Fiscal Summary (CQR-2)

To the extent possible, submission of OMRDD mid-year State Aid claims should not be delayed beyond the submission due date because one or more county operated or not-for-profit service providers have not submitted CQR-1s to the LGU. Once received, the delinquent CQR-1s should be submitted as a supplemental State Aid claim.

Instructions for completing State Aid vouchers, CQR-1s, CQR-2s and CQR-3s can be found elsewhere in this manual.

OMRDD LGU Final Claims

OMRDD final LGU State Aid claim packages consist of the following documents:

Non-NYC LGUs

- State Aid Voucher(s) (AC-1171)
- LGU Fiscal Summary (CQR-3)
- Consolidated Claim Reports (CCRs) for each county operated and not-for-profit service provider receiving State Aid through the LGU

NYC DOHMH

- State Aid Voucher(s) (AC-1171)
- NYC Quarterly Fiscal Summary (CQR-2)
- Consolidated Claim Reports (CCRs) for each county operated and not-for-profit service provider receiving State Aid through the NYC DOHMH

CCRs for both non-NYC LGUs and the NYC DOHMH consist of the CFR-i, CFR-iii, DMH-2, DMH-2A and DMH-3 schedules of the year-end CFR.

Note: *Incomplete final claim packages will not be accepted or processed.*

OMRDD Direct Contract Service Provider General Instructions

For each fiscal reporting period, OMRDD direct contract funded service providers are required to submit State Aid claim packages (generally quarterly and final packages).

Quarterly claim packages include a CFR-i schedule and an Agency Quarterly Fiscal Summary (CQR-1) schedule.

The final State Aid claim package covers the complete 12 month fiscal reporting period. Final claims consist of the Consolidated Claim Report (CCR). The CCR is comprised of the CFR-i,CFR-iii, DMH-2, DMH-2A and DMH-3 of the year-end Consolidated Fiscal Report (CFR).

Instructions for completing CQR-1s are included in this manual. Instructions for completing and submitting CFRs and CCRs are described in the Consolidated Fiscal Reporting and Claiming (CFR) Manual.

"Revised" State Aid claims should be submitted in the following instances:

- "Revised" State Aid claims should be submitted to correct erroneous *quarterly* claim schedules that were previously submitted to OMRDD.
- "Revised" *final* State Aid claims should be submitted to correct erroneous DMH-2, DMH-2A and/or DMH-3 claim schedules that were previously submitted to OMRDD.

OMRDD reserves the right to reject and return all or part of any State Aid claim package that does not comply with the procedures and policies outlined in this manual and/or any other expressed instructions, policies and/or procedures set forth by OMRDD.

OMRDD Direct Contract Service Provider Due Dates

OMRDD direct contract service providers State Aid claims are due for submission by the dates indicated in the payment schedule included in the fully executed contract with OMRDD.
Due dates for OMRDD direct contract service providers funded on a period other than January to December or July to June should submit mid-year, quarterly (if required)and final claims as follows:

Mid-Year Claims:	30 days after the end of the first six months of the twelve month contract period.
Quarterly Claims	30 days after the last day of each three month period of the 12 month contract period.
Final Claims:	120 days after the end of the twelve month contract period.

OMRDD Direct Contract Service Provider Quarterly Claims

Quarterly claims for OMRDD direct contract service providers consist of the following documents:

- State Aid Voucher(s) (AC-1171)
- Agency Identification and Certification Statement (CFR-i)
- Agency Quarterly Fiscal Summary (CQR-1)

OMRDD direct contract service providers will prepare quarterly State Aid Vouchers (AC-1171) in accordance with the instructions in this manual and will have it signed by the Executive Director or the designee.

OMRDD Direct Contract Service Provider Final Claims

The OMRDD direct contract service provider final State Aid claim package consists of the following documents:

- State Aid Voucher(s) (AC-1171)
- CFR-i, Agency Identification and Certification Statement
- CFR-iii, County/NYC Certification Statement
- DMH-2, Aid to Localities/ Direct Contract Summary
- DMH-2A, Aid to Localities/Direct Contract Equipment Summary
- DMH-3, Aid to Localities and Direct Contracts Program Funding Source Summary

OMRDD direct contract service providers will prepare a final State Aid Voucher (AC-1171) in accordance with the instructions in this manual and will have it signed by the Executive Director or the designee.

Note: *In the event that the CFR has not been completed in time to meet the direct contract submission due date, service providers should not delay in submitting this claim. Instead, preliminary ("estimated") claim schedules should be submitted by the submission date.*

In any instance where preliminary ("estimated") claim schedules have been submitted, service providers must forward the final claim schedules derived from the completed CFR as soon as they are available. The CFR derived schedules will then be used to replace the preliminary schedules already processed. Late submissions that require an additional State aid payment to the direct contract service provider may not be honored or processed given State appropriation lapse deadlines

This section of the manual describes the general overall processing of State Aid claim submissions by the DMH State Agencies.

Establishing Control Records

The first step in the DMH State Agencies processing of any State Aid claim is the establishment of control records. OASAS, OMH and OMRDD establish specific control records consistent with the level of control each State Agency requires.

For county operated service providers and not-for profit service providers funded through local contracts these controls are based on the information contained in the State Aid Approval Letters provided to Local Governmental Units (LGUs). Each funding DMH State Agency issues its own State Aid Approval Letter to an LGU for a given fiscal reporting period. The information contained in each DMH State Agency's Approval Letter differs in the amount of detail provided but all of them contain the approved funding level available for all service providers in the county, and the source of those funds. For more information on how State Aid Approval Letters are developed contact the appropriate DMH State Agency.

For service providers funded through a direct contract with a DMH State Agency the controls are included in the terms of the contract and the approved contract budget. As with the State Aid Approval Letters, each DMH State Agency's contract terms and contract budgets are formatted somewhat differently. For more information on how State contracts with service providers are developed contact the appropriate DMH State Agency.

Each of the DMH State Agencies reserves the right to add additional controls to LGUs, county operated service providers, local contract funded and direct contract funded not-for-profit service providers as circumstances warrant.

State Aid Claims Received by the DMH State Agencies

Each DMH State agency logs State Aid claims onto a claim submission status log. This log may be maintained in an electronic format or it may be maintained manually in a journal or ledger.

Regardless of the format, the claim submission status log includes the date the claim was received, the identity of the LGU or direct contractor submitting the claim and the claim period covered. When advance payments are due for processing, this submission status log is one of the reference sources used to determine if an advance will be provided.

Screening of State Aid Claims

Upon their receipt, State Aid Claims are screened for completeness in accordance with the State Aid Claims Preparation and Submission section of this manual. In addition, State Aid claims are also screened for other supporting documentation, if required.

For LGU claim submissions the funding DMH State Agencies will follow up with any LGU whose claim package does not include all of the required schedules and/or documentation for the service providers funded through that LGU. For direct contract claim submissions the funding DMH State Agencies will follow up directly with the service provider.

The DMH State Agencies may screen LGU and direct contract claims electronically or manually. Any required follow-up with an LGU or service provider may also be handled electronically or manually.

Review of State Aid Claims

OASAS, OMH and OMRDD will review all required LGU and direct contract service provider claims for the following:

- mathematical accuracy
- accuracy of program types and codes and indexes
- accuracy of funding source codes and indexes
- proper distribution of costs between the DMH State Agencies for shared programs
- proper allocation of agency administration expenses in accordance with the CFR methodology
- proper use of approved revenue allocation methodology
- proper application of the approved 1988 percentages (Appendix K) established for distribution of LGU administrative costs (program code 0890)
- proper application of weighted units of service methodology, if applicable
- existence of funding restrictions which prevent claims processing
- identification of unallowable costs. See Appendix X of this manual and the Consolidated Fiscal Reporting and Claiming (CFR) Manual for a list of some, but not all unallowable costs.

Within the budgetary control parameters established by each funding DMH State Agency, individual program columns may be analyzed for over-expenditures in budgeted expense categories. If a particular budget category is exceeded beyond these parameters, the excess expenses may be disallowed and non-funded if there is no evidence that a budget modification is in place or in process.

Each DMH State Agency will bring any adjustment and/or corrections resulting from the above review to the attention of the appropriate LGU or direct contract service provider. It is the responsibility of the LGU to ensure that county operated and local contract funded not-for-profit service providers are made aware of any and all changes made to their claims by the DMH State Agencies or the LGU.

Reconciliation of State Aid Claims to Advances

All DMH State Agencies: Final approved State Aid, as adjusted, *will* be reconciled against the advance payments provided to the LGU or direct contract service providers. The amount to be reconciled will include current year advances as well as unused advance balances from prior fiscal years. In addition, adjustments to payments made to LGUs and direct contract service providers shall also take into account any disallowances resulting from fiscal audits conducted by the Office of the State Comptroller, Federal Government, LGU and/or OASAS, OMH and OMRDD audit staffs.

Any questions regarding adjustments, corrections and payment reconciliations should be directed to the appropriate DMH State agency claims staff indicated in Section 1 of this manual.

The State Aid Voucher (AC-1171) is used by the NYS Office of Alcoholism and Substance Abuse Services (OASAS) and the NYS Office of Mental Retardation and Developmental Disabilities (OMRDD) to provide a certified statement of expenditures as a provision of receiving State Aid under Mental Hygiene Law. It also establishes a basis for reconciling advance payments made to Local Governmental Units (LGUs) and direct contract funded service providers.

The NYS Office of Mental Health (OMH) does not require the submission of State Aid Vouchers for advance payments or State Aid claim payments.

The NYS Office of Alcoholism and Substance Abuse Services (OASAS) only requires the submission of State Aid Vouchers by direct contract service providers.

General Instructions

1. State Aid Vouchers contain the following information relevant to the payee:

    - Identification of the funding State Agency (OASAS or OMRDD),
    - the name and address of the payee,
    - the payee identification number,
    - reference information that will be printed on the check stub to identify the payment to the payee,
    - identification of the period the advance payment or State Aid claim covers, and
    - payee certification that the advance payment requested or State Aid claim is in accordance with all applicable laws or regulations

2. State Aid Vouchers may be completed using the multi-part form issued by the Office of the State Comptroller or a computer generated facsimile.

3. Manually completed vouchers *must* be prepared using blue or black ink or typewritten.

4. Computer generated State Aid Voucher facsimiles *must* be identical reproductions of the multi-part form.

5. All State Aid Vouchers submitted *must* be legible.

6. All advance payments requested, expenditures and revenues reported and/or State Aid claimed *must* be rounded to the nearest whole dollar.

    Exception: *OMRDD rate-based State Aid programs must use exact calculations.*

7. In this section of the manual “municipality” refers to counties, cities, towns, villages, boroughs and/or any other district incorporated for local self government. Also, for the purposes of this manual, the term “municipality” will also include public schools and school districts.

8. OASAS and OMRDD reserve the right to reject and return any State Aid Vouchers that

do not comply with the policies and procedures described in these instructions.

LGU Instructions

LGUs are required to complete and submit State Aid Vouchers to OMRDD as part of their mid-year and final year-end State Aid claim packages.

Voucher Number

Make no entry.

Originating Agency (Box 1)

Enter the acronym for OMRDD as follows:

NYS OMRDD

Orig. Agency Code

Enter the five (5) digit agency code for the State Agency indicated in box 1 as follows:

OMRDD: 51000

Interest Eligible (Y/N)

Make no entry.

Payment Date (MM) (DD) (YY)

Make no entry.

OSC Use Only

Make no entry.

Liability Date (MM) (DD) (YY)

Make no entry.

Payee ID (Box 2) & Additional

Enter the 12 digit Municipality Code assigned to the LGU by the Office of the State Comptroller. Enter the first nine (9) digits of the code in the Payee ID box and the remaining three (3) digits in the Additional box.

Zip Code (Box 3)

Enter the zip code of the city, town or village where the office of the county fiscal officer is located.

Route

Make no entry.

Payee Name, Address, City, State & Zip Code (Box 4)

Enter the *title* of the county fiscal officer and the street address, city, state and zip code for the county fiscal officer. *Do not* enter the name of the county fiscal officer.

Payee Amount

Make no entry.

MIR Date (MM) (DD) (YY)

Make no entry.

IRS Code

Make no entry.

IRS Amount

Make no entry.

Stat. Type

Make no entry.

Statistic

Make no entry.

Indicator-Dept.

Make no entry.

Indicator-Statewide

Make no entry.

Ref./Inv. No. (MM) (DD) (YY)

Enter information that will identify the payment generated by the voucher. Up to 20 characters (alphabetic and/or numeric) may be used in any combination.

The information entered in this box will be printed on the check stub of any payment generated by this voucher.

Ref./Inv. Date (MM) (DD) (YY)

Make no entry.

Date Paid (Box 6)

Make no entry.

Check or Voucher No. (Box 6)

Make no entry.

Description of Charges (Box 6)

Enter the period covered by the State Aid claim as follows:

Expenses for the period January 1, 200X through June 30, 200X

or

Expenses for the period 01/01/0X – 06-30-0X

Note: For revised State Aid claims, identify the period covered as described above followed by "Revision # 1". If there are additional revisions follow the same naming convention using the next number (Revision #2, Revision #3, etc.)

Amount (Box 6)

Enter the total expenses reported in column 2, line 25 of the LGU Fiscal Summary (CQR-3) schedule that will be submitted as part of the mid-year or year-end State Aid claim package.

Total

Enter the total expenses reported in column 2, line 25 of the LGU Fiscal Summary (CQR-3) schedule that will be submitted as part of the mid-year or year-end State Aid claim package.

Less Receipts

Enter the total revenues reported in column 2, line 26 of the LGU Fiscal Summary (CQR-3) schedule that will be submitted as part of the mid-year or year-end State Aid claim package.

Net

Enter the total net operating costs reported in column 2, line 27 of the LGU Fiscal Summary (CQR-3) schedule that will be submitted as part of the mid-year or year-end State Aid claim package.

State Aid Claimed

Enter the total State Aid claimed in column 2, line 25 of the LGU Fiscal Summary (CQR-3) schedule that will be submitted as part of the mid-year or year-end State Aid claim package.

State Aid Program or Applicable Statute (Box 7)

Make no entry.

Payee Certification (Box 8)

Signature in Ink:	The State Aid Voucher *must* be signed by the county fiscal officer (Treasurer, Controller, etc.) or duly authorized representative. The signature *must* be in blue or black ink. *Rubber stamp signatures are not allowed.*
Date:	Enter the date the State Aid Voucher was signed by the LGU Chief Fiscal Officer or duly authorized representative.
Title:	Enter the title of the county fiscal officer or duly authorized representative (Treasurer, Controller, etc.).
Name of Municipality:	Enter the county name of the LGU.

For State Use Only Section

Make no entry.

State Comptroller's Pre-Audit Section

Make no entry.

Expenditure Section

Make no entry.

Liquidation Section

Make no entry.

Direct Contract Funded Service Provider Instructions

Direct contract funded service providers are required to complete and submit State Aid Vouchers to OASAS and OMRDD in order to receive advance payments and as part of their mid-year and final year-end State Aid claim packages. The instructions that follow are broken into two (2) sections, one for advance payment voucher completion and one for State Aid claim voucher completion.

Direct Contract Advance Payment Voucher

Voucher Number

Make no entry.

Originating Agency (Box 1)

Enter the acronym for OASAS or OMRDD as follows:

NYS OASAS
NYS OMRDD

Orig. Agency Code

Enter the five (5) digit agency code for the State Agency indicated in box 1 as follows:

OASAS: 53000
OMRDD: 51000

Interest Eligible (Y/N)

Make no entry.

Payment Date (MM) (DD) (YY)

Make no entry.

OSC Use Only

Make no entry.

Liability Date (MM) (DD) (YY)

Make no entry.

Payee ID (Box 2) & Additional

Municipalities: Enter the 12 digit Municipality Code assigned to the LGU by the Office of the State Comptroller. Enter the first nine (9) digits of the code in the Payee ID box and the remaining three (3) digits in the Additional box.

Not-for Profits: Enter the service provider's corporate Federal Tax Identification Number. This number *must* match the Federal Tax Identification Number included in the service provider's fully executed direct contract.

Zip Code (Box 3)

Municipalities: Enter the 12 digit Municipality Code assigned to the LGU by the Office of the State Comptroller. Enter the first nine (9) digits of the code in the Payee ID box and the remaining three (3) digits in the Additional box.

Not-for Profits: Make no entry.

Route

Make no entry.

Payee Name, Address, City, State & Zip Code (Box 4)

If a Municipality or Not for Profit has signed up with the Office of the State Comptroller (OSC) for Electronic Funds Transfer (EFT) payments, all information must be consistent with that provided to OSC or payment will not be paid via EFT.

Municipalities: Enter the *title* of the municipal fiscal officer and the street address, city, state and zip code for the municipal fiscal officer. *Do not* enter the name of the municipal fiscal officer.

Not-for Profits: Enter the corporate name, street address, city, state and zip code of the service provider's corporate headquarters.

Payee Amount

Make no entry.

MIR Date (MM) (DD) (YY)

Make no entry.

IRS Code

Make no entry.

IRS Amount

Make no entry.

Stat. Type

Make no entry.

Statistic

Make no entry.

Indicator-Dept.

Make no entry.

Indicator-Statewide

Make no entry.

Ref./Inv. No. (MM) (DD) (YY)

Enter information that will identify the advance payment generated by the voucher. Up to 20 characters (alphabetic and/or numeric) may be used in any combination.

The information entered in this box will be printed on the check stub of the advance payment generated by the voucher. For example, an OMRDD 1st quarter advance may be given a reference/invoice number of "OMRDD Jan-Feb 04 Adv".

Ref./Inv. Date (MM) (DD) (YY)

Make no entry.

Date Paid (Box 6)

Make no entry.

Check or Voucher No. (Box 6)

Make no entry.

Description of Charges (Box 6)

Enter the contract number and the period covered by the advance payment as follows:

C-000001: Advance payment for the period January 1, 200X through June 30, 200X
or
C-000001: Advance payment for the period 01/01/0X – 06-30-0X

Amount (Box 6)

Enter the amount of the advance payment requested.

Note: OASAS providers should Make No Entry; amount will be calculated by OASAS.

Total

Enter the amount of the advance payment requested.

Note: OASAS providers should Make No Entry; amount will be calculated by OASAS.

Less Receipts

Make no entry.

Net

Enter the amount of the advance payment requested.

Note: OASAS providers should Make No Entry; amount will be calculated by OASAS.

State Aid Claimed

Enter the amount of the advance payment requested.

Note: OASAS providers should Make No Entry; amount will be calculated by OASAS.

State Aid Program or Applicable Statute (Box 7)

Make no entry.

Payee Certification (Box 8)

Municipalities:	Signature in Ink:	The State Aid Voucher *must* be signed by the municipal fiscal officer (Treasurer, Controller, etc.) or duly authorized representative. The signature *must* be in blue or black ink. *Rubber stamp signatures are not allowed.*
	Date:	Enter the date the State Aid Voucher was signed by the municipal fiscal officer or duly authorized representative.
	Title:	Enter the title of the municipal fiscal officer or duly authorized representative (Treasurer, Controller, etc.).
	Name of Municipality:	Enter the county name of the LGU.
Not-for-Profits:	Signature in Ink:	The State Aid Voucher *must* be signed by the chief executive officer or duly authorized representative.

	The signature *must* be in blue or black ink. *Rubber stamp signatures are not allowed.*
Date:	Enter the date the State Aid Voucher was signed by the chief executive officer or duly authorized representative.
Title:	Enter the title of the chief executive officer or duly authorized representative (Treasurer, Controller, etc.).
Name of Municipality:	Make no entry.

For State Use Only Section

Make no entry.

State Comptroller's Pre-Audit Section

Make no entry.

Expenditure Section

Make no entry.

Liquidation Section

Make no entry.

Direct Contract State Aid Claim Voucher

Voucher Number

Make no entry.

Originating Agency (Box 1)

Enter the acronym for OASAS or OMRDD as follows:

NYS OASAS
NYS OMRDD

Orig. Agency Code

Enter the five (5) digit agency code for the State Agency indicated in box 1 as follows:

OASAS: 53000
OMRDD: 51000

Interest Eligible (Y/N)

Make no entry.

Payment Date (MM) (DD) (YY)

Make no entry.

OSC Use Only

Make no entry.

Liability Date (MM) (DD) (YY)

Make no entry.

Payee ID (Box 2) & Additional

Municipalities: Enter the 12 digit Municipality Code assigned to the LGU by the Office of the State Comptroller. Enter the first nine (9) digits of the code in the Payee ID box and the remaining three (3) digits in the Additional box.

Not-for Profits: Enter the service provider's corporate Federal Tax Identification Number. This number *must* match the Federal Tax Identification Number included in the service provider's fully executed direct contract.

Zip Code (Box 3)

Municipalities: Enter the 12 digit Municipality Code assigned to the LGU by the Office of the State Comptroller. Enter the first nine (9) digits of the code in the Payee ID box and the remaining three (3) digits in the Additional box.

Not-for Profits: Make no entry.

Route

Make no entry.

Payee Name, Address, City, State & Zip Code (Box 4)

If a Municipality or Not for Profit has signed up with the Office of the State Comptroller (OSC) for Electronic Funds Transfer (EFT) payments, all information must be consistent with that provided to OSC or payment will not be paid via EFT.

Municipalities: Enter the *title* of the municipal fiscal officer and the street address, city, state and zip code for the municipal fiscal officer. *Do not* enter the name of the municipal fiscal officer.

Not-for Profits: Enter the corporate name, street address, city, state and zip code of the service provider's corporate headquarters.

Payee Amount

Make no entry.

MIR Date (MM) (DD) (YY)

Make no entry.

IRS Code

Make no entry.

IRS Amount

Make no entry.

Stat. Type

Make no entry.

Statistic

Make no entry.

Indicator-Dept.

Make no entry.

Indicator-Statewide

Make no entry.

Ref./Inv. No. (MM) (DD) (YY)

Enter information that will identify the payment generated by the voucher. Up to 20 characters (alphabetic and/or numeric) may be used in any combination.

The information entered in this box will be printed on the check stub of any payment generated by this voucher. For example, an OASAS mid-year claim may be given a reference/invoice number of “OASAS Jan-Jun 04 Clm”.

Ref./Inv. Date (MM) (DD) (YY)

Make no entry.

Date Paid (Box 6)

Make no entry.

Check or Voucher No. (Box 6)

Make no entry.

Description of Charges (Box 6)

Enter the contract number and the period covered by the State Aid claim as follows:

C-000001: Expenses for the period January 1, 200X through June 30, 200X
or
C-000001: Expenses for the period 01/01/0X – 06-30-0X

Note: For revised State Aid claims, identify the period covered as described above followed by "Revision # 1". If there are additional revisions follow the same naming convention using the next number (Revision #2, Revision #3, etc.)

Amount (Box 6)

Note: OASAS providers should Make No Entry; amount will be calculated by OASAS.

Quarterly Claim: Enter the total expenses reported in column 3, line 9 of the Agency Quarterly Fiscal Summary (CQR-1) schedule that will be submitted as part of the first, second or third quarter State Aid claim package.

Mid-Year Claim: Enter the total expenses reported in column 3, line 9 of the Agency Quarterly Fiscal Summary (CQR-1) schedule that will be submitted as part of the mid-year State Aid claim package.

Final Year-End Claim: Enter the total expenses reported in the Total column, line 30 of the Aid to Localities and Direct Contracts Program Funding Source Summary (DMH-3) schedule that will be submitted as part of the final year-end State Aid claim package.

Total

Note: OASAS providers should Make No Entry; amount will be calculated by OASAS.

Quarterly Claim: Enter the total expenses reported in column 3, line 9 of the Agency Quarterly Fiscal Summary (CQR-1) schedule that will be submitted as part of the first, second or third quarter State Aid claim package.

Mid-Year Claim: Enter the total expenses reported in column 3, line 9 of the

Agency Quarterly Fiscal Summary (CQR-1) schedule that will be submitted as part of the mid-year State Aid claim package.

Final Year-End Claim: Enter the total expenses reported in the Total column, line 30 of the Aid to Localities and Direct Contracts Program Funding Source Summary (DMH-3) schedule that will be submitted as part of the final year-end State Aid claim package.

Less Receipts

Note: OASAS providers should Make No Entry; amount will be calculated by OASAS.

Quarterly Claim: Enter the total revenues reported in column 3, line 13 of the Agency Quarterly Fiscal Summary (CQR-1) schedule that will be submitted as part of the first, second or third quarter State Aid claim package.

Mid-Year Claim: Enter the total revenues reported in column 3, line 13 of the Agency Quarterly Fiscal Summary (CQR-1) schedule that will be submitted as part of the mid-year State Aid claim package.

Final Year-End Claim: Enter the total revenues reported in the Total column, line 31 of the Aid to Localities and Direct Contracts Program Funding Source Summary (DMH-3) schedule that will be submitted as part of the final year-end State Aid claim package.

Net

Note: OASAS providers should Make No Entry; amount will be calculated by OASAS.

Quarterly Claim: Enter the total net operating costs reported in column 3, line 14 of the Agency Quarterly Fiscal Summary (CQR-1) schedule that will be submitted as part of the first, second or third quarter State Aid claim package.

Mid-Year Claim: Enter the total net operating costs reported in column 3, line 14 of the Agency Quarterly Fiscal Summary (CQR-1) schedule that will be submitted as part of the mid-year State Aid claim package.

Final Year-End Claim: Enter the total net operating costs reported in the Total column, line 32 of the Aid to Localities and Direct Contracts Program Funding Source Summary (DMH-3) schedule that will be submitted as part of the final year-end State Aid claim package.

State Aid Claimed

Note: OASAS providers should Make No Entry; amount will be calculated by OASAS.

Enter the total State Aid claimed for the quarterly, mid-year or year-end State Aid claim

package.

State Aid Program or Applicable Statute (Box 7)

Make no entry.

Payee Certification (Box 8)

Municipalities:	Signature in Ink:	The State Aid Voucher *must* be signed by the municipal fiscal officer (Treasurer, Controller, etc.) or duly authorized representative. The signature *must* be in blue or black ink. *Rubber stamp signatures are not allowed.*
	Date:	Enter the date the State Aid Voucher was signed by the municipal fiscal officer or duly authorized representative.
	Title:	Enter the title of the municipal fiscal officer or duly authorized representative (Treasurer, Controller, etc.).
	Name of Municipality:	Enter the county name of the LGU.
Not-for-Profits:	Signature in Ink:	The State Aid Voucher *must* be signed by the chief executive officer or duly authorized representative. The signature *must* be in blue or black ink. *Rubber stamp signatures are not allowed.*
	Date:	Enter the date the State Aid Voucher was signed by the chief executive officer or duly authorized representative.
	Title:	Enter the title of the chief executive officer or duly authorized representative.
	Name of Municipality:	Make no entry.

For State Use Only Section

Make no entry.

State Comptroller's Pre-Audit Section

Make no entry.

Expenditure Section

Make no entry.

Liquidation Section

Make no entry

The CQR-1 Agency Quarterly Fiscal Summary schedule is used to report intra-year expenses, revenues, net operating costs and funding sources for programs receiving Aid to Localities (State Aid) funding from the NYS Office of Alcoholism and Substance Abuse Services (OASAS), NYS Office of Mental Health (OMH) and NYS Office of Mental Retardation and Developmental Disabilities (OMRDD).

Note: *The NYS Office of Mental Health (OMH) does not require the submission of intra-year claims. Accordingly, OMH does not require the submission of CQR-1 claim schedules.*

General Instructions

The CQR-1 is only used to report intra-year fiscal information. A final CQR-1 is *not* required and should *not* be submitted. For final claim submissions the consolidated Claim Report (CCR) schedules included as part of the year-end Consolidated Fiscal Report (CFR) are used.

1. Separate OASAS-specific and/or OMRDD-specific CQR-1 schedules *must* be prepared.

2. Separate OASAS-specific and/or OMRDD-specific CQR-1 schedules *must* be prepared for each county in which the service provider operates programs and/or from which the service provider receives State Aid funding.

3. Additional CQR-1 continuation schedules are required if:

   i. a service provider operates more than four (4) programs and/or

   ii. receives State Aid reimbursement from more than four (4) unique funding code and funding code index combinations.

4. The overall flow of the CQR-1 schedule is as follows:

   - Column 1 displays the service provider's approved budget.

   - Column 2 displays the service provider's cumulative (local fiscal year-to-date) approved expenses, revenues and net operating costs.

   - Column 3 displays the sum of columns 4–7 (or more if required) exclusive of lines 15–19, 23–25, 31–33, 39–41 and 47-49.

Note: OASAS expects all service providers to use approved CFRS Software to complete Intra-year Fiscal Reporting documents and to submit those documents via the Internet. At this time, paper copies are still required to be sent directly to OASAS' Bureau of Financial Management.

Heading Instructions – CQR-1.1 and CQR-1.2

State Agency *

Indicate whether the reported programs are for either OASAS services or OMRDD services.

Fiscal Period *

Enter the beginning and ending dates of the complete 12 month fiscal reporting period (01/01/XX to 12/31/XX, 07/01/XX to 06/31/XY, etc.). *Do not* enter the dates of the quarter or mid-year period for which expenses and revenues are being reported.

Quarter Reported *

Indicate the specific intra-year claim period the CQR-1 covers (i.e. 1st quarter, 2nd quarter, mid-year, etc.).

Agency Name *

Enter the name of the organization (service provider) operating the reported program(s).

Prepared by *

Enter name of person that prepared the CQR-1 and can answer questions about the information contained in the document.

Telephone *

Enter the preparer's telephone number.

Agency Code *

Enter the five (5) digit code assigned to the organization operating the reported program(s).

County Name and Code *

Enter the name and associated two (2) digit code for the county where the reported programs operated and/or were funded through a local county contract. Please see Appendix C of this manual and the Consolidated Fiscal Reporting and Claiming Manual (CFR Manual) for a list of New York State counties and their associated county codes.

LGU *

Local contract funded service providers:	Enter the name of the Local Governmental Unit (LGU) that contracted for the reported programs.

Direct contract funded service providers: Make no entry.

** Complete this at the top of each page of the CQR-1.1 & CQR-1.2.*

LGU Approval By *

LGUs: Enter the name of the individual representing the LGU) that has reviewed and approved the expenses, revenues, net operating costs and funding code information reported on the CQR-1.

Local contract funded service providers: Make no entry.

Direct contract funded service providers: Make no entry.

Program Type *

For each reported program, enter the type of program operated using the program names in Appendices E and G of this manual and the CFR Manual.

Program Code & Program Code Index *

For each reported program, enter the applicable OASAS or OMRDD program code and program code index. Please see Appendices E and G of this manual and the CFR Manual for complete listings of valid OASAS and OMRDD program codes. Program code indexes are assigned as follows:

OASAS: Use the same array of program codes and indexes as were used during the prior reporting period unless programs have been combined, added or removed from OASAS funding for this reporting period. If programs have been added or removed from OASAS funding, consult with the OASAS Field Office for the appropriate array of program codes and indexes to be used.

OMRDD: OMRDD programs reported on a program type basis (expenses and revenues aggregated and reported in one (1) column) and programs codes 0053, 0054, 0090, 0091, 0200, 0202, 1090, 1091, 2090, 2091, 3090, 4090, 5090, 5091, 6090 and 6091 use index code “00”. For all other OMRDD programs use “01” for the first occurrence of each program type, “02” for the second occurrence, “03” for the third occurrence, etc (e.g. Family Support).

Accounting Method (CQR-1.1 only) *

For each reported program, enter the method of accounting used i.e., accrual, modified accrual or cash.

** Complete this at the top of each page of the CQR-1.1 & CQR-1.2.*

Line Instructions – CQR-1.1 - Expenses (Columns 4-7)

1. *Personal Services*

For each reported program, enter the personal services expenses for the reporting period. Do not include agency administration personal services on this line.

2. *Vacation Leave Accruals*

For each reported program, enter the vacation leave accruals (current quarter or mid-year adjustments) that correspond to the personal services reported on line 1. *Do not include agency administration vacation leave accruals on this line.*

OASAS Note: *OASAS does not allow service providers to budget for* or *claim vacation leave accruals for State Aid reimbursement.*

3. *Fringe Benefits*

For each reported program, enter the fringe benefits that correspond to the personal services reported on line 1. Include FICA, hospitalization, retirement benefits, group life insurance, etc. *Do not include agency administration fringe benefits on this line.*

Note: *Fringe benefits expenses are allowable expenses to the extent that they are reasonable and available to all employees.*

4. *Other Than Personal Services*

For each reported program, enter the OTPS expenses for the reporting period. Include food, repairs and maintenance, utilities, telephones, minor expensed equipment (equipment costing less than $1,000 per unit *and* having a useful life of less than two (2) years), supplies, etc. *Do not include agency administration OTPS expenses on this line.*

5. *Equipment – Provider Paid*

For each reported program, enter the equipment-related expenses for the reporting period. Include the cost of any vehicle and equipment leases on this line. *Do not include agency administration equipment expenses on this line. Also, do not include any equipment expenses reported on line 4, OTPS.*

OASAS Note: *OASAS does not allow service providers to budget for or claim equipment depreciation for State Aid reimbursement. All equipment must be expensed in the year of purchase.*

OMRDD Note: *Equipment costing $1,000 or more* and *having a useful life of two (2) or more years may be depreciated or expensed in the year of purchase.*

6. *Property – Provider Paid*

For each reported program, enter the property-related expenses for the reporting period. Include property lease costs, building depreciation, property casualty insurance, etc. *Do not include agency administration property expenses on this line.*

OASAS Note: *OASAS does not allow service providers to budget for or claim property depreciation for State Aid reimbursement. Only the actual property-related costs incurred can be claimed.*

7. *Agency Administration*

For each applicable program, enter the allocated agency administration expenses for the reporting period. Total county operated and not-for-profit service provider agency administration expenses must be allocated to OASAS, OMRDD and all other funding sources using the ratio value methodology.

Note: County operated service providers *must* allocate agency administration expenses to programs other than LGU administration (program code 0890). LGU administration is considered a unique cost center separate and distinct from agency administration expenses incurred by other county operated programs. Agency administration expenses for the management and oversight of all county operated programs other than program code 0890 *cannot* be included in the expenses reported under program code 0890. Please see Appendix I and Appendix K of this manual and the CFR Manual for more detailed information on agency administration and LGU administration.

8. *Adjustments/Non-Allowable Costs*

For each reported program enter the adjustments to reported expenses and/or non-allowable expenses for the reporting period. *The amount(s) entered on line 8 cannot be a negative number.* Please refer to Appendix X of this manual and the CFR Manual for descriptions of some, but not all, non-allowable expenses.

9. *Total Expenses*

For each reported program, enter the sum of lines 1-7 minus line 8.

Line Instructions – CQR-1.1 - Revenues (Columns 4-7)

10. *Please Check (OMRDD Only)*

For each reported program, indicate the type of revenue allocation methodology used (Participant Specific or Non-Participant Specific).

11. *Medicaid Revenue*

For each reported program, enter the actual Medicaid revenue received for the

reporting period. (See notes to line 12 below.)

12. *Non-Medicaid Revenue*

For each reported program, enter the revenues received from all sources other than Medicaid for the reporting period. This includes DSH revenue and revenue received from Medicaid MCOs.

Disproportionate Share (DSH): *OASAS service providers should report any DSH revenue received on line 12, Non-Medicaid Revenue.*

Medicaid Managed Care: *Revenues received directly from a Medicaid Managed Care Organization (MCO) should be reported on line 12, Non-Medicaid Revenue.*

13. *Total Revenues*

For each reported program, enter the sum of lines 11 and 12.

14. *Net Operating Costs*

For each reported program, enter the result of line 9 minus line 13.

Line Instructions – CQR-1.1 - Miscellaneous (Columns 4-7)

15. *State Contract Number/Local Contract Number*

For each reported program, enter the contract number as follows:

State Contract Number: For direct contracts with OASAS or OMRDD, enter the State contract number.

LGU Contract Number: For local contracts with a county, enter the local contract number if one is assigned.

Note: *A State or LGU contract number must be entered. If the funding LGU does not use contract numbers, enter the first seven (7) letters of the county name as a proxy. If the county name is seven (7) letters or less, enter the complete county name.*

Note: OASAS would prefer that all County operated and Not for Profit service providers funded through a local contract with a County use the first seven (7) letters of the County name rather than an LGU contract number.

16. *Total Persons Served (OMH Only)*

For OASAS and OMRDD programs, make no entry.

17. *Total Units of Service*

For each applicable program reported, enter the units of service provided during the reporting period.

Note: *Reporting units of service may not be applicable for certain types of programs. Please see Appendices E and G of this manual and the CFR Manual to determine if units of service should be reported for a specific type of program.*

18. *Gross Cost Per Unit*

For each program with reported units of service, enter the gross cost per unit of service for the reporting period. The gross cost per unit of service is calculated by dividing the total program expenses reported on line 9 by the total program units of service reported on line 17. The gross cost per unit of service should be calculated to the nearest hundredth place (XXX.XX).

19. *Net Cost Per Unit*

For each program with reported units of service, enter the net cost per unit of service for the reporting period. The net cost per unit of service is calculated by dividing the total program net operating costs expenses reported on line 14 by the total program units of service reported on line 17. The net cost per unit of service should be calculated to the nearest hundredth place (XXX.XX).

20. *Workshop Contract Sales (Direct)*

OASAS: Make no entry.

OMRDD: For each reported workshop program, enter the industrial contract sales revenues for the reporting period.

21. *Local Government (OASAS Only)*

OASAS: For each reported program, enter the amount of local government contribution (local county tax) that is being applied against the net deficit for the reporting period. *Use this line only if one or more of the funding code and funding code indexes used on the CQR-1.2 reimburses State Aid at 100% of the net expenses reported.*

OMRDD: Make no entry.

22. *Voluntary Contributions*

OASAS: Make no entry. Voluntary contributions are budgeted for and reported as Non-Medicaid Revenue on line 12.

OMRDD: Make no entry.

Line Instructions – CQR-1.2 – General Funding Source Information

If expenses, revenues and net operating costs need to be distributed between funding codes, there are four ways this can be accomplished:

1. Expenses, revenues and net operating costs can be direct charged.

2. Expenses, revenues and net operating costs can be distributed using units of service. When using this method, the ratio of the units of service applied to a funding code or State Agency *must* be calculated using six decimal place multipliers (i.e. .123456). The sum of all multipliers used *must* equal 1.000000.

3. Expenses, revenues and net operating costs can be distributed using a ratio. When using this method, the ratio *must* be calculated using six decimal place multipliers (i.e. .123456). The sum of all multipliers used *must* equal 1.000000.

4. For OMRDD programs using the Participant Specific Revenue Allocation methodology, expenses are distributed between funding codes using units of service (see number 1 above). Revenues are direct charged to the appropriate funding code(s) based on the funding source and the consumers generating the revenues under that funding source.

Please check with the funding State Agency (OASAS or OMRDD) if you have any questions regarding the allocation methodology to be used.

Line Instructions – CQR-1.2 – Funding Code Information (Columns 4-7)

Lines 23, 31, 39 and 47 – Funding Code

For each reported program, enter the applicable three (3) digit funding code(s) used during the reporting period.

OASAS Note: OASAS funded county operated and not-for-profit service providers *must* also enter the alphabetic funding source index. The funding code and funding code index combinations used *must* be consistent with those used in the service provider's most recently approved budget.

County operated and local contract funded not-for-profit service providers can find the correct funding code and funding code indexes to use on the most recently issued OASAS Approval Letter for the fiscal reporting period.

Direct contract funded county operated and not-for-profit service providers can find the correct funding code and funding code indexes to use on the most recent Appendix B of their fully executed contract with OASAS.

Only one (1) unique funding code or funding code/funding code index combination can be used on each line.

Lines 24, 32, 40 and 48 – Number of Persons Served (OMH Only)

For OASAS and OMRDD programs, make no entry.

Lines 25, 33, 41 and 49 – Units of Service

For each applicable program, enter the units of service provided during the reporting period.

Note: *Reporting units of service may not be applicable for certain types of programs. Please see Appendices E and G of this manual and the CFR Manual to determine if units of service should be reported for a specific type of program.*

Lines 26, 34, 42 and 50 – Total Expenses

For each unique funding code and funding code index combination used in a reported program, enter the allocated portion of the expenses entered on CQR-1.1, line 9.

Lines 27, 35, 43 and 51 – Revenue: Medicaid

For each unique funding code and funding code index combination used in a reported program, enter the allocated portion of the expenses entered on CQR-1.1, line 11.

Lines 28, 36, 44 and 52 – Revenue: Other

For each unique funding code and funding code index combination used in a reported program, enter the allocated portion of the expenses entered on CQR-1.1, line 12.

Lines 29, 37, 45 and 53 – Total Revenues

For each unique funding code and funding code index combination used in a reported program, enter the allocated portion of the expenses entered on CQR-1.1, line 13.

Lines 30, 38, 46 and 54 – Net Operating Costs

For each unique funding code and funding code index combination used in a reported program, enter the allocated portion of the expenses entered on CQR-1.1, line 13.

The CQR-2 NYC Fiscal Summary schedule is completed by the NYC Department of Health and Mental Hygiene (NYC DOHMH). It summarizes mid-year and year-end fiscal activity for service providers receiving Aid to Localities (State Aid) funding from the NYS Office of Alcoholism and Substance Abuse Services (OASAS) and the NYS Office of Mental Retardation and Developmental Disabilities (OMRDD) through a local contract with the NYC DOHMH. Additionally, the CQR-2 is used to establish accountability for advance payments made to local contract funded service providers by the NYC DOHMH.

Note: *The NYS Office of Mental Health (OMH) does not require the submission of the CQR-2 schedule.*

General Instructions

1. Separate OASAS-specific and/or OMRDD-specific CQR-2 schedules *must* be prepared.

2. The mid-year CQR-2 reports fiscal data for the first six (6) months of the fiscal reporting period. The year end CQR-2 reports fiscal data for the full 12 months of the fiscal reporting period.

3. Additional CQR-2 continuation schedules are required if:

   i. there are more than five (5) funded service providers and/or

   ii. more than five (5) unique funding code and funding code index combinations.

4. The overall flow of the CQR-2 schedule is as follows:

   - Column 2 displays the sum of columns 3–7 (or more if required) exclusive of line 30.

Heading Instructions

State Agency *

Indicate whether the reported programs are for either OASAS services or OMRDD services.

Fiscal Period *

Enter the beginning and ending dates of the complete 12 month fiscal reporting period (i.e. 07/01/XX to 06/31/XY).

Quarter Reported *

Indicate the specific intra-year claim period the CQR-1 covers (i.e. 1st quarter, 2nd quarter, mid-year, etc.).

* *Complete this at the top of each page of the CQR-2.*

Prepared by *

Enter name of person that prepared the CQR-2 and can answer questions about the information contained in the document.

Title *

Enter the title of the person that prepared the CQR-2 and can answer questions about the information contained in the document.

Telephone *

Enter the preparer's telephone number.

LGU Approval By *

Enter the name of the individual representing the NYC DOHMH that has reviewed and approved the expenses, revenues, net operating costs and funding code information reported on the CQR-2.

Title *

Enter the title of the person that reviewed and approved the CQR-2.

Date Approved *

Enter the date the LGU reviewed CQR-2 was approved.

Funding Code Information (Columns 3-7) *

For each reported service provider, enter the applicable three (3) digit funding code(s) used during the reporting period.

OASAS Note: Funding codes used for OASAS funded county operated and not-for-profit service providers *must* also include the alphabetic funding source index. The funding code and funding code index combinations used *must* be consistent with those used in the service provider's most recently approved budget.

County operated and local contract funded not-for-profit service providers can find the correct funding code and funding code indexes to use on the most recently issued OASAS Approval Letter for the fiscal reporting period.

Only one (1) unique funding code or funding code/funding code index combination can be used on each line.

** Complete this at the top of each page of the CQR-2.*

Line Instructions

Lines 1-20 – Agency Identification Information

Lines 1, 5, 9, 13 and 17 – Agency Name
Enter the names of the organizations operating the reported programs.

Lines 2, 6, 10, 14 and 18 – Agency Code
Enter the five (5) digit codes assigned to the organizations operating the reported program(s).

Lines 4, 8, 12, 16 and 20 – NYC Contract Number
Enter the NYC DOHMH contract number associated with the agencies entered on lines 1, 5, 9, 13 and 17.

Column 3-7 – Lines 1-20 - Service Provider Funding Code Information

Note: There will be more than seven (7) columns if more than five (5) unique funding code and funding code indexes are used. Please see page 23.1, General Instructions, item 3 for information on the use of CQR-2 continuation sheets.

Lines 1, 5, 9, 13 and 17 – Total Expenses
For each service provider reported, enter the total expenses for the reporting period in the appropriate funding code/index columns.

Lines 2, 6, 10, 14 and 18 – Revenues
For each service provider reported, enter the total revenues for the reporting period in the appropriate funding code/index columns.

Lines 3, 7, 11, 15 and 19 – Net Operating Costs
For each service provider reported, enter the total net operating costs for the reporting period in the appropriate funding code/index columns.

Lines 4, 8, 12, 16 and 20 – Advances
For each service provider reported, enter the total advance payments provided for the reporting period in the appropriate funding code/index columns.

Columns 3-7 – Lines 3-24 – Page Total Information

Note: There will be more than seven (7) columns if more than five (5) unique funding code and funding code indexes are used. Please see page 23.1, General Instructions, item 3 for information on the use of CQR-2 continuation sheets.

21. ***Total Expenses***
Enter the sum of the amounts reported on lines 1, 5, 9, 13 and 17 for each funding code and funding code index combination used.

22. ***Revenues***
Enter the sum of the amounts reported on lines 2, 6, 10, 14 and 18 for each funding code and funding code index combination used.

23. ***Net Operating Costs***
Enter the sum of the amounts reported on lines 3, 7, 11, 15 and 19 for each funding code and funding code index combination used.

24. ***Advances***
Enter the sum of the amounts reported on lines 4, 8, 12, 16 and 18 for each funding code and funding code index combination used.

Columns 3-7 – Lines 25-31 – NYC Total Information (Last page(s) of CQR-2 only)

Note: There will be more than seven (7) columns if more than five (5) unique funding code and funding code indexes are used. Please see page 23.1, General Instructions, item 3 for information on the use of CQR-2 continuation sheets.

25. ***Total Expenses***
On the last set of CQR-2 continuation sheets, enter the sum of the amount(s) reported on line 21 of each CQR-2 for each funding code and funding code index combination used.

26. ***Revenues***
On the last set of CQR-2 continuation sheets, enter the sum of the amount(s) reported on line 22 of each CQR-2 for each funding code and funding code index combination used.

27. ***Net Operating Costs***
On the last set of CQR-2 continuation sheets, enter the sum of the amount(s) reported on line 23 of each CQR-2 for each funding code and funding code index combination used.

28. ***Advance Amount***
On the last set of CQR-2 continuation sheets, enter the sum of the amount(s) reported on line 24 of each CQR-2 for each funding code and funding code index combination used.

29. ***Total Net/Advances***
On the last set of CQR-2 continuation sheets, enter the sum of the amounts reported on lines 27 and 28 of each CQR-2 for each funding code and funding code index combination used.

30. ***Reimbursement Rate***
On the last set of CQR-2 continuation sheets, enter the applicable reimbursement rate for each funding code and funding code index combination used.

31. ***State Aid Total***
On the last set of CQR-2 continuation sheets enter the State Aid amount calculated by applying the reimbursement rate entered on line 30 to the amount entered on line 29 for each funding code and funding code index combination used.

Column 2 State Agency Total Information - Lines 1-20

Lines 1, 5, 9, 13 and 17 – Total Expenses
For each service provider reported, enter the sum of the expenses reported on these lines in columns 3-7.

Lines 2, 6, 10, 14 and 18 – Revenues
For each service provider reported, enter the sum of the revenues reported on these lines in columns 3-7.

Lines 3, 7, 11, 15 and 19 – Net Operating Costs
For each service provider reported, enter the sum of the net operating costs reported on these lines in columns 3-7.

Lines 4, 8, 12, 16 and 20 – Advances
For each service provider reported, enter the sum of the advances reported on these lines in columns 3-7.

Column 2 – Page Total Information - Lines 21-24

21. ***Total Expenses***
Enter the sum of the amounts reported on lines 1, 5, 9, 13 and 17 of column 2.

22. ***Revenues***
Enter the sum of the amounts reported on lines 2, 6, 10, 14 and 18 of column.

23. ***Net Operating Costs***
Enter the sum of the amounts reported on lines 3, 7, 11, 15 and 19 of column 2.

24. ***Advances***
Enter the sum of the amounts reported on lines 4, 8, 12, 16 and 18 of column 2.

Column 2 – NYC Total Information - Lines 25-31 (Last page(s) of CQR-2 only)

25. ***Total Expenses***
On the last set of CQR-2 continuation sheets, enter the sum of the amounts reported on line 21 of each CQR-2 submitted.

26. ***Revenues***
On the last set of CQR-2 continuation sheets, enter the sum of the amounts reported on line 22 of each CQR-2 submitted.

27. ***Net Operating Costs***
On the last set of CQR-2 continuation sheets, enter the sum of the amounts reported on line 23 of each CQR-2 submitted.

28. ***Advance Amount***
On the last set of CQR-2 continuation sheets, enter the sum of the amounts reported on line 24 of each CQR-2 submitted.

29. ***Total Net/Advances***
On the last set of CQR-2 continuation sheets, enter the sum of the amounts reported on lines 27 and 28 of each CQR-2 submitted.

30. ***Reimbursement* Rate**
Make no entry.

31. ***State Aid Total***
On the last set of CQR-2 continuation sheets, enter the sum of the amounts reported on line 31 of each CQR-2 submitted.

The CQR-3 LGU Fiscal Summary schedule is completed by Local Governmental Units (LGUs) located outside of the City of New York. It summarizes mid-year and year-end fiscal activity for service providers receiving Aid to Localities (State Aid) funding from the NYS Office of Alcoholism and Substance Abuse Services (OASAS) and the NYS Office of Mental Retardation and Developmental Disabilities (OMRDD) through a local contract with the LGU.

Additionally, the CQR-3 is used to establish the basis for reimbursing small counties 75% of the first $100,000 in net operating costs incurred under Regular Local Assistance funding (funding code 001). Small counties are defined as counties with populations less than 200,000.

Note: *The NYS Office of Mental Health (OMH) does not require the submission of the CQR-3 schedule. The OMH Aid to Localities Financial System (ALFS) will generate the CQR-3 schedule for each LGU.*

General Instructions

1. Separate OASAS-specific and/or OMRDD-specific CQR-3 schedules *must* be prepared.

2. Mid-year and year-end CQR-3 schedules are completed. Mid-year CQR-3s cover the first six (6) months of the fiscal reporting period and year-end CQR-3s cover the full 12 month fiscal reporting period.

3. The source(s) of the fiscal information summarized on the CQR-3 is as follows:

   Mid-Year Claims: Use the funding code and funding code index information reported on page CQR-1.2 of the Agency Quarterly Fiscal Summaries (CQR-1s) submitted by county operated and local contract funded not-for-profit service providers.

   Year-end Claims: Use the funding code and funding code index information reported on the Aid to Localities and Direct Contracts Program Funding Source Summaries (DMH-3s) submitted by county operated and local contract funded not-for-profit service providers.

4. Additional CQR-3 continuation schedules are required if:

   i. there are more than seven (7) funded service providers and/or

   ii. more than five (5) unique funding code and funding code index combinations.

5. The overall flow of the CQR-3 schedule is as follows:

   - Column 2 displays the sum of columns 3–7 (or more if required) exclusive of line 28.

6. *Do not* include OASAS and OMRDD direct contract funded programs' fiscal

information on the CQR-3 schedule.

Heading Instructions

State Agency *

Indicate whether the reported programs are for either OASAS services or OMRDD services.

Fiscal Period *

Enter the beginning and ending dates of the complete 12 month fiscal reporting period (i.e. 01/01/XX to 12/31/XX).

Quarter Reported *

Indicate the specific claim period the CQR-3 covers (i.e. 1st quarter, 2nd quarter, mid-year or final).

County Name and Code *

Enter the name and associated two (2) digit code for the county where the reported programs operated and/or were funded through a local county contract. Please see Appendix C of this manual and the Consolidated Fiscal Reporting and Claiming Manual (CFR Manual) for a list of New York State counties and their associated county codes.

Prepared by *

Enter name of person that prepared the CQR-3 and can answer questions about the information contained in the document.

Title *

Enter the title of the person that prepared the CQR-3 and can answer questions about the information contained in the document.

Telephone *

Enter the preparer's telephone number.

LGU Approval By *

Enter the name of the individual representing the LGU that has reviewed and approved the expenses, revenues, net operating costs and funding code information reported on the CQR-3.

** Complete this at the top of each page of the CQR-3.*

Title *

Enter the title of the person that reviewed and approved the CQR-3.

Date Approved *

Enter the date the LGU reviewed CQR-3 was approved.

Funding Code Information (Columns 3-7) *

Note: There will be more than seven (7) columns if more than five (5) unique funding code and funding code indexes are used. Please see page 24.1, General Instructions, item 4 for information on the use of CQR-3 continuation sheets.

For each reported service provider, enter the applicable three (3) digit funding code(s) used during the reporting period.

OASAS Note: Funding codes used for OASAS funded county operated and not-for-profit service providers *must* also include the alphabetic funding source index. The funding code and funding code index combinations used *must* be consistent with those used in the service provider's most recently approved budget.

County operated and local contract funded not-for-profit service providers can find the correct funding code and funding code indexes to use on the most recently issued OASAS Approval Letter for the fiscal reporting period.

Only one (1) unique funding code or funding code/funding code index combination can be used on each line.

Line Instructions

Lines 1-21 – Agency Identification Information

Lines 1, 4, 7, 10, 16 and 19 – Agency Name

Enter the names of the organizations operating the reported programs.

Lines 1, 4, 7, 10, 16 and 19 – Agency Code

Enter the five (5) digit codes assigned to the organizations operating the reported program(s).

** Complete this at the top of each page of the CQR-3.*

Columns 3-7 – Lines 1-21 - Service Provider Funding Code Information

Note: There will be more than seven (7) columns if more than five (5) unique funding code and funding code indexes are used. Please see page 24.1, General Instructions, item 4 for information on the use of CQR-3 continuation sheets.

Lines 1, 4, 7, 10, 16 and 19 – Total Expenses
For each service provider reported, enter the total expenses for the reporting period in the appropriate funding code/index columns.

Lines 2, 5, 8, 11, 14, 17 and 20 – Revenues
For each service provider reported, enter the total revenues for the reporting period in the appropriate funding code/index columns.

Lines 3, 6, 9, 12, 15, 18 and 21 – Net Operating Costs
For each service provider reported, enter the total net operating costs for the reporting period in the appropriate funding code/index columns.

Columns 3-7 – Lines 22-24 – Page Total Information

22. ***Total Expenses***
Enter the sum of the amounts reported on lines 1, 4, 7, 10, 16 and 19 for each funding code and funding code index combination used.

23. ***Revenues***
Enter the sum of the amounts reported on lines 2, 5, 8, 11, 14, 17 and 20 for each funding code and funding code index combination used.

24. ***Net Operating Costs***
Enter the sum of the amounts reported on lines 3, 6, 9, 12, 15, 18 and 21 for each funding code and funding code index combination used.

Columns 3-7 – Lines 25-31 – County Total Information (Last page(s) of CQR-2 only)

25. ***Total Expenses***
On the last set of CQR-3 continuation sheets, enter the sum of the amount(s) reported on line 22 of each CQR-3 for each funding code and funding code index combination used.

26. ***Revenues***
On the last set of CQR-3 continuation sheets, enter the sum of the amount(s) reported on line 23 of each CQR-3 for each funding code and funding code index combination used.

27. ***Net Operating Costs***
On the last set of CQR-3 continuation sheets, enter the sum of the amount(s) reported on line 24 of each CQR-3 for each funding code and funding code index combination

used.

28. ***Reimbursement Rate***

For each funding code and funding code index combination used in columns 3-7, enter the applicable reimbursement rate for that funding code and funding code index combination on the last set of CQR-3 continuation sheets.

29. ***State Aid Subtotal***

For each funding code and funding code index combination used in columns 3-7, enter the State Aid amount calculated by applying the reimbursement rate entered on line 28 to the amount entered on line 27 of the last set of CQR-3 continuation sheets.

30. ***Extra $25,000***

In the column used for funding code 001 on the last set of CQR-3 continuation sheets, LGUs with a population of 200,000 or less should calculate an additional 25% reimbursement of the net operating costs reported on line 27 up to the approved OASAS or OMRDD limit.

31. ***State Aid Total***

On the last set of CQR-3 continuation sheets, enter the sum of the amounts reported on lines 30 and 31.

Column 2 State Agency Total Information - Lines 1-20

Lines 1, 4, 7, 10, 16 and 19 – Total Expenses

For each service provider reported, enter the sum of the expenses reported on these lines in columns 3-7.

Lines 2, 5, 8, 11, 14, 17 and 20 – Revenues

For each service provider reported, enter the sum of the revenues reported on these lines in columns 3-7.

Lines 3, 6, 9, 12, 15, 18 and 21 – Net Operating Costs

For each service provider reported, enter the sum of the net operating costs reported on these lines in columns 3-7.

Column 2 – Page Total Information - Lines 22-24

32. ***Total Expenses***

Enter the sum of the amounts reported on lines 1, 4, 7, 10, 16 and 19 of column 2.

33. Revenues

Enter the sum of the amounts reported on lines 2, 5, 8, 11, 14, 17 and 20 of column 2.

34. Net Operating Costs

Enter the sum of the amounts reported on lines 3, 6, 9, 12, 15, 18 and 21 of column 2.

Column 2 – County Total Information - Lines 25-31 (Last page(s) of CQR-2 only)

35. Total Expenses

On the last set of CQR-3 continuation sheets, enter the sum of the amounts reported on line 22 of each CQR-3 submitted.

36. Revenues

On the last set of CQR-3 continuation sheets, enter the sum of the amounts reported on line 23 of each CQR-3 submitted

37. Net Operating Costs

On the last set of CQR-3 continuation sheets, enter the sum of the amounts reported on line 24 of each CQR-3 submitted.

38. Reimbursement Rate

Make no entry.

39. State Aid Subtotal

On the last set of CQR-3 continuation sheets, enter the State Aid amount calculated for each funding code and funding code index combination used in columns 3-7 by applying the reimbursement rate entered on line 28 to the amount entered on line 27.

40. Extra $25,000

On the last set of CQR-3 continuation sheets, LGUs with population of 200,000 or less should calculate an additional 25% reimbursement of the net operating costs reported on line 27 under funding code 001.

41. State Aid Total

On the last set of CQR-3 continuation sheets, enter the sum of the amounts reported on lines 30 and 31.

Adaptive Equipment: Devices, aids, controls, appliances or supplies of either a communication or adaptive type, determined necessary to enable the person to increase his or her ability to function in a home and community based setting with independence and safety.

Affiliate: An associate with respect to a partnership - each partner within the partnership; a corporation - each officer, director, principal stockholder and controlling person within the corporation; a natural person - each member of the person's immediate family; each partnership; and each partner of the person; each corporation in which the person or any affiliate of the person is an officer, director, principal stockholder, or controlling person.

Agency Administration: Those expenses which are not directly attributable to a specific program but rather to the overall administration of all the programs, or a support function for the agency, such as personnel, that is not specific to any particular program, service, or contract.

Amortization: The process of writing off a regular portion of the cost of an intangible asset over a fixed period of time. Refer to Appendix O - Guidelines for Depreciation and Amortization.

Arm's Length Transaction: A transaction entered into by unrelated parties, each acting in their own best interest. It is assumed that in this type of transaction, the prices used are the fair market values of the property or services being transferred in the transaction.

Asset: Property and service rights, measurable in terms of money, which the entity acquires for their economic benefit or value.

Building: The basic structure, shell and additions. The remainder is identified as fixed equipment. Land costs are not depreciable and should be excluded from building costs.

Capital Expenditure: The acquisition of both property and equipment having a useful life which extends over more than one accounting period. A capital expenditure either adds a fixed asset unit or increases the value of an existing fixed asset. Expenditures benefiting only the current year should be treated as an operating expense.

Closely Allied Entities (CAEs): Closely Allied Entities include corporations, partnerships, unincorporated associations or other bodies that have been formed or are organized to provide financial assistance and aid for the benefit of the service provider or receive financial assistance and aid from the service provider. Financial assistance and aid include engaging in fund raising activities, administering funds, holding title to real property, having an interest in personal property of any nature, and engaging in any other activities for the benefit of the service provider or the closely allied entity.

Community Support Programs (CSP revenue): Medicaid revenue that is added to the Medicaid rate of certain OMH outpatient programs in proportion to the amount of community support program state and local net deficit funding that has previously been replaced by CSP. This Medicaid revenue is regulated in law 14NYCRR Part 588.

Comprehensive Outpatient Programs (COPS revenue): Medicaid revenue that is added to the Medicaid rate of certain OMH outpatient programs in proportion to the amount of state and local

net deficit funding that has previously been replaced by COPS. This Medicaid revenue is regulated in law 14NYCRR parts 592.

Controlling Party: Any person or organization who by reason of a direct or indirect ownership interest or designated responsibility (whether of record or beneficial) has the ability, acting either alone or in concert with others with ownership interest or designated responsibility, to direct or cause the direction of the management or policies of a corporation, partnership or other entity. Neither the commissioner nor any employee of DMH, SED nor any member of a local legislative body of a county or municipality, nor any county or municipal official except when acting as the administrator of a program shall, by reason of his or her official position, be deemed a controlling party of any corporation, partnership or other entity. For SED purposes, "Controlling Party" shall have the same meaning as "less-than-arm's-length relationship" as defined in Section 200.9 of the SED Commissioner's Regulations.

Department of Mental Hygiene (DMH): The agency in New York State charged with the responsibility for providing services for the care and treatment of mental illness, mental retardation and developmental disabilities, alcoholism and substance abuse as well as the prevention of such conditions.

Depreciation: The process of writing off the acquisition cost of a fixed asset over the estimated useful life. Depreciation is the decline in economic potential of limited life assets originating from wear and tear, natural deterioration through interaction of the elements, and technical obsolescence. Refer to Appendix O - Guidelines for Depreciation and Amortization.

Disproportionate Share Income (DSH): Disproportionate Share Income (DSH) Legislation (Bill #5550-A, 1997-98 Budget initiative) signed by the Governor in 1997 allows for the Office of Mental Health and the Office of Alcohol and Substance Abuse Services to replace net deficit financing with Disproportionate Share Funding in Article 28 voluntary non-profit general hospitals. Payments shall not exceed such general hospital's cost of providing services to uninsured and Medicaid patients after taking into consideration all other Medical Assistance received, including disproportionate share payments made to general hospital and payments from and on behalf of such uninsured patients and shall also not exceed the amount of State Aid and Local Aid Grants for which the hospital or its successor would have been eligible pursuant to Articles 25 & 41 of the Mental hygiene Law for fiscal year 1996-97.

Expensed Adaptive Equipment: Includes the costs of all adaptive equipment purchased during the CFR reporting period with a value of less than $1,000 or a useful life of less than two years.

Expensed Equipment: Includes the costs of all equipment purchased during the CFR reporting period with a value of less than $1,000 or a useful life of less than two years.

Federal Grants: Sources of revenue in the form of grants received directly from the federal government to support service provider programs.

Federal Medicaid Salary Sharing: A Medicaid revenue. Through the Federal Medicaid Salary Sharing program, counties can be reimbursed for part of the cost of county staff time related to the management of certain aspects of mental health or mental retardation Medicaid programs.

(However, costs associated with staff who operate Medicaid programs or who provide direct care are not included.)

Fixed Equipment: Includes attachments to buildings, such as wiring, electrical fixtures, plumbing, elevators, heating and air conditioning systems, etc. The general characteristics of this equipment are: a) affixed to the building and not subject to transfer; and b) minimum useful life of two years, but shorter than the life of the building to which affixed.

Fund Raising: All expenses associated with the activities a service provider may use to supplement its revenues in obtaining contributions, gifts, grants, etc. All fund raising and special events expenses (personal services, leave accruals, fringe benefits, OTPS, equipment and property) are to be included as “other programs” (column 7) on Schedule CFR-2 and the appropriate operating expenses (personal services, leave accruals, fringe benefits and OTPS) included on Schedule CFR-3, line 48.

Historical Cost: The cost at date of acquisition of an asset, less discounts plus all normal incidental costs necessary to bring the asset into existing use and location.

Immediate Family: A relationship including brother, sister, grandparent, grandchild, first cousin, aunt or uncle, spouse, parent, or child of such person, whether such relationship arises by reason of birth, marriage or adoption.

Improvement(s): A capital expenditure which extends or improves the useful life of an asset or improves it in some manner over and above the original asset. Thus, if an expenditure adds years to an asset's useful life or improves its rate of output, it would be considered an improvement. In contrast, a maintenance or repair expense is not capitalized.

In-Contract vs. Out-of-Contract: Programs that are approved to receive Aid to Localities net deficit funding on the Consolidated Budget Report (CBR) are designated as in-contract (i.e., utilizing one of the funding codes listed in Appendix N, except for the non-funded code 090), while programs not receiving Aid to Localities net deficit funding (i.e., utilizing funding code 090) are regarded on the CBR as out-of-contract. See Appendix Z for Policy Statement and Procedures.

Leasehold: An agreement between the lessee and the lessor specifying the lessee's rights to use the leased property for a given time at a specified rental payment.

Leasehold Improvements: Modifications or upgrades made by a lessee to leased property which revert to the lessor at the expiration of the lease term. See Appendix O for amortization rules.

Local Governmental Unit (LGU) Administration: A program category which includes all local government costs related to administering services for the mentally ill, mentally retarded and developmentally disabled, alcohol and/or substance abuser. These costs should not include agency and program administration costs, but should include community service board costs.

Maintenance in Lieu of Rent: Expenditures should include the rent of premises or the cost to own and maintain the premises. If the building is occupied jointly with other tenants, this cost

should be allocated on the basis of the service provider's proportionate share of the total usable square footage of the building.

Medicaid: A revenue category representing payments received for services to eligible participants under the combined Federal/State program which pays for medical care for those who cannot afford it, regardless of age.

Medicare: A revenue category representing payments received for services to eligible participants under the Federal programs which pay for medical care for those 65 years old or over and/or disabled under Title II and in receipt of Social Security disability benefits for 24 months.

Moveable Equipment: The general characteristics of this equipment are:

a. capable of being moved as distinguished from fixed equipment;
b. a unit cost sufficient to justify ledger control;
c. sufficient size and identity to make control feasible by means of identification tags; and
d. a minimum useful life of approximately two years.

Refer to Appendix O - Guidelines for Depreciation and Amortization.

Net Deficit Funding: All revenues resulting from:

a. direct contract with New York State Department of Mental Hygiene (DMH);
b. contract with Local Government Unit (LGU) (State and County Share);

Not-for-Profit Organization: A group, institution, or corporation formed for the purpose of providing goods and services under a policy where no individual (e.g., trustee) will share in any profits or losses of the organization. Profit is not the primary goal of not-for-profit entities. Profit may develop, however, under a different name (e.g., surplus, increase in fund balance). Assets are typically provided by sources that do not expect repayment or economic return. Usually, there are restrictions on resources obtained. All income and earnings will be used exclusively for the purpose of the corporation and no part shall inure to the benefit or profit of any private individual firm or corporation.

Organizational Expense: Expenditures incurred in starting a business. They include attorney's fees and various registration fees paid to State governments. The total of all the expenditures is considered to be an intangible asset. Theoretically, these expenditures may benefit the company throughout its operating life, but must be amortized. Refer to Appendix O for amortization rules.

Principal Stockholder: A person who beneficially owns, holds or has the power to vote, ten percent (10%) or more of any class of securities issued by said corporation.

Program Administration Expense: Administrative expenses directly attributable to a specific program which may include but are not limited to personal services and fringe benefits of Program Director, Billing Personnel, etc.

Related Party Transaction: A transaction between the reporting entity, its affiliates, principal owners, management and members of their immediate families and any other party with which the reporting entity may deal when one party has the ability to significantly influence management or operating policies of the other to the extent that one of the transacting parties might be prevented from fully pursuing its own separate interests.

Salvage Value: The amount expected to be realized upon the sale or other disposition of the asset when it is no longer useful to the program.

Site Specific Methodology: An accepted cost development and reporting methodology in which costs of programs are related to specific sites where services are provided, as opposed to aggregating and averaging costs for all sites (cost averaging).

State Grant: A revenue category which represents income from State agencies other than OASAS, OMH, OMRDD and SED.

Third Party: A revenue category which includes payments received for services to participants from private health insurance coverage such as Blue Cross, etc.

Unit of Service: The workload measure by which programs are evaluated. Units of service vary with the type of program provided.

The following lists commonly used acronyms:

Acronym	Translation
ABI	Affirmative Business/Industry
ACD	Agency for Child Development
ACE	Assisted Competitive Employment
ACT	Assertive Community Treatment
BCM	Blended Case Management
CAE	Closely Allied Entity
CBR	Consolidated Budget Report
CCR	Consolidated Claiming Report
CDT	Continuing Day Treatment
CEO	Chief Executive Officer
CFDA	Catalog of Federal Domestic Assistance
CFR	Consolidated Fiscal Report
CFO	Chief Fiscal Officer
CMHS	Federal Community Mental Health Services Block Grant
COPs	Comprehensive Outpatient Providers
CPA	Certified Public Accountant
CPEP	Comprehensive Psychiatric Emergency Program
CPSE	Committee for Preschool Special Education
CQR	Claiming Quarterly Report
CRS	Community Rehabilitation and Support
CSE	Committee for Special Education
CSP	Community Support Program
CSS	Community Support Services
DA	Dormitory Authority
DCJS	Division of Criminal Justice Services
DCN	Document Control Number
DHHS	Federal Department of Health and Human Services
DMH	Department of Mental Hygiene
DMV	Department of Motor Vehicles
DOH	Department of Health
DOL	Department of Labor
EOB	Extended Observation Bed
FBTP	Family-Based Treatment Program
FTE	Full Time Equivalent
GAAP	Generally Accepted Accounting Principles
HCBS	Home and Community Based Services
HUD	Federal Department of Housing and Urban Development
ICF	Intermediate Care Facility
ICM	Intensive Case Management
IDEA	Federal Individuals with Disabilities Education Act Funds
IPRT	Intensive Psychiatric Rehabilitation Treatment
IR	Intensive Rehabilitation

Acronym	Translation
IRA	Individual Residential Alternative
ISO	Information Services Office
ISP	Individual Service Plan
JAIBG	Federal Juvenile Accountability Incentive Block Grant
JCAHO	Joint Commission on the Accreditation of Health Care Organizations
LA	Local Assistance
LGU	Local Governmental Unit
LTSE	Long Term Sheltered Employment
MCFFA	Medical Care Facilities Finance Agency
MHL	Mental Hygiene Law
MICA	Mentally Ill Chemical Abusers
NDF	Net Deficit Funding
NYCDOHMH	New York City Department of Health and Mental Hygiene
NYCRR	New York Codes, Rules, and Regulations
OASAS	Office of Alcoholism and Substance Abuse Services
OCFS	Office of Children and Family Services
OISE	Ongoing Integrated Supported Employment
OMH	Office of Mental Health
OMRDD	Office of Mental Retardation and Developmental Disabilities
OSC	Office of the State Comptroller
OTPS	Other Than Personal Services
PDG	Program Development Grant
PHP	Permanent Housing Program
PROS	Personalized Recovery Oriented Services
PRU	Program Reporting Unit
RCCA	Residential Care Center for Adults
RIV	Reinvestment
RTF	Residential Treatment Facility
RV	Ratio Value
SCM	Supportive Case Management
SED	State Education Department
SEIT	Special Education Itinerant Teacher
SPMI	Seriously and Persistently Mentally Ill
SRO	Single Room Occupancy
SSA	Social Security Administration
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
TEP	Transitional Employment Placement
TM	Transitional Management
TUBS	Temporary Use Beds
UPK	Universal Pre-K
VESID	Vocational and Educational Services for Individuals with Disabilities

New York State Counties:

County	Code	County	Code
Albany	01	Niagara	32
Allegany	02	Oneida	33
Bronx	03	Onondaga	34
Broome	04	Ontario	35
Cattaraugus	05	Orange	36
Cayuga	06	Orleans	37
Chautauqua	07	Oswego	38
Chemung	08	Otsego	39
Chenango	09	Putnam	40
Clinton	10	Queens	41
Columbia	11	Rensselaer	42
Cortland	12	Richmond	43
Delaware	13	Rockland	44
Dutchess	14	St. Lawrence	45
Erie	15	Saratoga	46
Essex	16	Schenectady	47
Franklin	17	Schoharie	48
Fulton	18	Schuyler	49
Genesee	19	Seneca	50
Greene	20	Steuben	51
Hamilton	21	Suffolk	52
Herkimer	22	Sullivan	53
Jefferson	23	Tioga	54
Kings	24	Tompkins	55
Lewis	25	Ulster	56
Livingston	26	Warren	57
Madison	27	Washington	58
Monroe	28	Wayne	59
Montgomery	29	Westchester	60
Nassau	30	Wyoming	61
New York	31	Yates	62

Statewide – OMH Budgets and Claims Only

OMH Statewide Contracts (OMH Only) – Use County Code 63 (January to December) or 64 (July to June)
OMH Legislative Special Projects (OMH Only) - Use County Code 64
All NYC boroughs for OMH – Use County Code 31

Non-New York State Counties:

All Non-New York State Counties – Use County Code 80

Not included in this manual.

Please see the Consolidated Fiscal Reporting and Claiming Manual.

Below is an alphabetical listing of program types and the corresponding codes grouped by service type. Following this alphabetic list is a numeric list of program definitions and the corresponding codes.

Service providers who operate more than one certified chemical dependence site must report each site separately (in accordance with the approved budget) by indexing the appropriate program code as indicated in the examples below:

Example: A service provider operating an outpatient medically supervised chemical dependence clinic with three certified sites would report program codes 3520-00, 3520-01, 3520-02.

Program Name	Service Type	Program Code
Crisis		
Primary Care Alcoholism (Alcohol Crisis Center)	Crisis	2020
Medically Supervised Withdrawal Services – Inpatient/Residential	Crisis	3039
Medically Supervised Withdrawal Services – Outpatient	Crisis	3059
Medically Managed Detoxification	Crisis	3500
Medically Monitored Withdrawal	Crisis	3510
Inpatient		
Chemical Dependence Inpatient Rehabilitation Services	Inpatient	3550
Residential Chemical Dependency Program for Youth (Short-Term)	Inpatient	4030
Methadone		
Methadone-to-Abstinence – Outpatient	Methadone	0605
Methadone Maintenance – Residential	Methadone	2030
Methadone Maintenance – Outpatient	Methadone	2050
Enhanced Methadone Maintenance – Outpatient	Methadone	2058
KEEP Units – Prison – Methadone	Methadone	2110
KEEP Units – Outpatient – Methadone	Methadone	2150
Methadone-to-Abstinence – Residential	Methadone	6030
Methadone-to-Abstinence – Day Service	Methadone	6040
Outpatient		
Outpatient Chemical Dependence for Youth	Outpatient	0140
Compulsive Gambling Treatment	Outpatient	2780
Medically Supervised Outpatient	Outpatient	3520
Outpatient Rehabilitation Services	Outpatient	3530
Enhanced Medically Supervised Outpatient	Outpatient	3528
Enhanced Outpatient Rehabilitation Services	Outpatient	3538

Program Name	Service Type	Program Code
Specialized Services Substance Abuse Programs	Outpatient	4045
Prevention		
Underage Drinking Prevention (eff. July 2004)	Prevention	0507
Compulsive Gambling Education, Assessment & Referral Services	Prevention	2790
Community Mobilization	Prevention	3001
Regional Prevention Resource Centers	Prevention	3100
Chemical Dependence Prevention Services	Prevention	5550
Program Support		
Criminal Justice Intervention/DWI	Program Support	0830
Road to Recovery Supplemental Payments	Program Support	0893
Intake, Outreach & Referral Units	Program Support	4071
Support Services - Medical/Legal/Psychological	Program Support	4073
Support Services - Educational	Program Support	4074
Community Services	Program Support	4075
Resource	Program Support	4077
Program Administration	Program Support	4078
COSA (Children of Substance Abusers)	Program Support	4175
AIDS Resource	Program Support	4470
Legislative Member Item	Program Support	4778
Residential		
NY NY III: Post-Treatment Housing	Residential	3270
NY NY III: Housing for Persons at Risk of Homelessness	Residential	3370
Permanent Supported Housing	Residential	3470
Residential Rehabilitation Services for Youth (RRSY)	Residential	3551
Intensive Residential	Residential	3560
Community Residential	Residential	3570
Supportive Living	Residential	3580
Residential Chemical Dependency Program for Youth (Long-Term)	Residential	4060
Treatment Support		
Job Placement Initiative	Treatment Support	0465
Case Management	Treatment Support	0810
Local Governmental Unit (LGU) Administration	Treatment Support	0890
Shelter Plus Care Housing	Treatment Support	3070
Managed Addiction Treatment Services (MATS)	Treatment Support	3810
Vocational Rehabilitation	Treatment Support	4072
Dual Diagnosis Coordinator	Treatment Support	5990

0140 - Outpatient Chemical Dependence for Youth

Such programs serve youth between the ages 12 and 18 by providing a drug-free setting supporting abstinence from alcohol and/or other substances of abuse. Active treatment is rendered through multi-disciplinary clinical services designed to assist the youth in achieving and maintaining an abstinent lifestyle and to serve youth whose normal adolescent development, in one or more major life areas, has been impaired as a result of the use of alcohol and/or other substances by a parent or significant other.

Units Of Service:

Visit 30 minutes-less than two hours: A period of scheduled participation by a client which includes the receipt of one or more types of treatment services for at least 30 minutes but less than two hours in duration.

Visit two hours-less than four hours: A period of scheduled participation by a client which includes the receipt of one or more types of treatment services for at least two hours but less than four hours in duration.

Visit of four or more hours: A period of scheduled participation by a client which includes the receipt of one or more types of treatment services for at least four hours in duration.

Off-Premises Treatment Visits: A period of direct evaluation, therapy or counseling provided by an ambulatory alcoholism treatment program to a client in his or her home or convenient place thereto when the client is temporarily or intermittently unable to be served at the alcoholism treatment program premises. Visits should extend at least 30 minutes.

Socialization/Recreation Visit: A period of attendance in an alcoholism program or on the premises thereof during which only companionship, social activity, recreation or a combination thereof is received by the client.

0465 - Job Placement Initiative

Vocational rehabilitation focusing on job referrals and placement.

0507 - Underage Drinking Prevention

Activities designed to decrease underage drinking.

0605 - Methadone-to-Abstinence – Outpatient

Methadone treatment delivered on an ambulatory basis in gradually decreasing doses to the point of abstinence, followed by continued drug-free treatment.

0810 - Case Management

Activities aimed at linking the client to the service system and at coordinating the various services in order to achieve a successful outcome. The objective of case management in a mental health system is continuity of care and service. Services may include linking, monitoring and case-specific advocacy.

Linking: The process of referring or transferring a client to all required internal and external services that include the identification and acquisition of appropriate service resources.

Monitoring: Observation to assure the continuity of service in accordance with the client's treatment plan.

Case-Specific Advocacy: Interceding on the behalf of a client to assure access to services required in the individual service plan. Case management activities are expediting and coordinative in nature rather than the primary treatment services ordinarily provided by a therapist.

Case management services are provided to enrolled clients for whom staff are assigned a continuing case management responsibility. Thus, routine referral would not be included unless the staff member making the referral retains a continuing active responsibility for the client throughout the system of service.

Units of Service:
Direct staff hours: The number of staff hours spent by staff in providing case management services face-to-face or by telephone directly to clients or collaterals.

Indirect staff hours: The number of staff hours spent by staff in providing case management services on behalf of clients other than face-to-face or by telephone directly with clients or collaterals.

0830 - Criminal Justice Intervention/ DWI

A program consisting of organized activities designed to ensure that persons who are charged with an alcohol-related driving or other criminal offense are screened and evaluated for the need for alcoholism treatment. Some activities are carried out directly by criminal justice agencies, and others by the staff of a local governmental unit (LGU) to ensure that appropriate treatment services are made available to persons identified to be in need. Included in this category are LGU coordination activities related to alternatives to incarceration and non-treatment interventions. This category does not include DMV-certified programs for drinking drivers often operated by local councils on alcoholism, which may also be used for intervention purpose.

0890 - Local Governmental Unit (LGU) Administration

The Local Governmental Unit is defined in Article 41 of the Mental Hygiene Law. This program category includes all local government costs related to administering mental hygiene services that are provided by a local government or by a voluntary agency pursuant to a contract with a local governmental unit. LGU Administration is funded cooperatively by OASAS, OMH and/or OMRDD. As such, this program is reported as a shared program on the core schedules (CFR-1 through CFR-6) of the CFR. LGU Administration expenses and revenues related to each State Agency are reported on State Agency specific claiming schedules (DMH-2 and DMH-3). **Note:** This program type is exempt from the Ratio Value allocation of agency administration.

0893 - Road to Recovery Supplemental Payments

2020 - Primary Care Alcoholism Program (Alcohol Crisis Center)

A program providing inpatient care in a medically supported environment until clients are safely alcohol-free and can be referred to an appropriate treatment program. Persons admitted to this program may present a need for withdrawal from alcohol but will not require medical services at the time of admission. Length of stay is generally 3 to 14 days. Supportive services are provided by the program during the time necessary to link clients with needed treatment and rehabilitation services. Continued stay beyond three to five days is based on the availability of a suitable alternative environment in which effective treatment can be continued. When operated in an alcoholism treatment center, these programs may provide medical detoxification which is not provided in a freestanding program based in an alcohol crisis center.

2030 - Methadone Maintenance – Residential

Methadone treatment programs (MTPs) that administer methadone by prescription, in conjunction with a variety of other rehabilitative assistance in a residential setting, to control the physical problems associated with heroin dependence and to provide the opportunity for patients to make major life-style changes over time.

2050 - Methadone Maintenance – Outpatient

Methadone treatment delivered primarily on an ambulatory basis, with most programs located in either a community or hospital setting. Methadone is administered daily at a stabilized dose over an extended period of time.

2058 - Enhanced Methadone Maintenance – Outpatient

2110 - *Keep* Units – Prison – Methadone

Methadone treatment delivered in a prison setting. KEEP is an interim (not more than 180 days) protocol that provides intensive medical and support services in order to evaluate the long-term treatment needs of patients

2150 - *Keep* Units – Outpatient – Methadone

Methadone treatment delivered on an ambulatory basis. KEEP is an interim (not more than 180 days) protocol that provides intensive medical and support services in order to evaluate the long-term treatment needs of patients

2780 - Compulsive Gambling Treatment

To provide outpatient treatment to compulsive gamblers designed to reduce symptoms, improve functioning and provide ongoing support. A compulsive gambling treatment program shall provide assessment and treatment planning specific to compulsive gambling, screening and referral for other problems, financial management planning, connection to self help groups for compulsive gamblers, individual, group and family therapy specific to this diagnosis and crisis intervention.

2790 - Compulsive Gambling Education, Assessment and Referral Services

Promising prevention programs, activities and strategies that are targeted to decrease risk factors and increase protective factors related to problem gambling behaviors.

3001 - Community Mobilization

To bring science/evidence-based prevention strategies to locally identified risks and protective factors through local coalitions that develop strategic action plans. OASAS supports this initiative with a six-phase training process, using certified trainers and provision of technical assistance.

3039 - Medically Supervised Withdrawal Services – Inpatient/Residential

As defined in Part 816 of OASAS' regulations, medically supervised withdrawal services provided in an inpatient or residential setting must be provided under the supervision and direction of a licensed physician, and shall include medical supervision of persons undergoing moderate withdrawal or who are at risk of moderate withdrawal, as well as persons experiencing non-acute physical or psychiatric complications associated with their chemical dependence.

Such services are appropriate for persons who are intoxicated by alcohol and/or substances, who are suffering from mild withdrawal, coupled with situational crisis, or who are unable to abstain with an absence of past withdrawal complications.

3059 - Medically Supervised Withdrawal Services – Outpatient

As defined in Part 816 of OASAS' regulations, medically supervised withdrawal services provided in an outpatient setting must be provided under the supervision and direction of a licensed physician, and shall include medical supervision of persons undergoing moderate withdrawal or who are at risk of moderate withdrawal, as well as persons experiencing non-acute physical or psychiatric complications associated with their chemical dependence.

Such services are appropriate for persons who are intoxicated by alcohol and/or substances, who are suffering from mild withdrawal, coupled with situational crisis, or who are unable to abstain with an absence of past withdrawal complications.

3070 - Shelter Plus Care Housing

A federally funded program of housing assistance specifically targeted to homeless persons with disabilities and their families. For programs administered by OASAS and/or OMH, "persons with disabilities" are "persons who are seriously mentally ill and/or have chronic problems with alcohol, drugs or both". Funds may be used for the payment of rent stipends up to the federally-established Fair Market rent, and associated administrative expenses. OASAS and OMH require any not-for-profit agency in receipt of these funds to report the funds in a separate program column, indexed if necessary on the CBR and CCR. Shelter Plus Care Grants are made for five or ten years at a time. This program code is used in cases where the federal funds flow through OASAS or OMH.

3100 - Regional Prevention Resource Centers

As training and technical assistance centers, these regional prevention resource centers will work in partnership with OASAS, counties, and OASAS-funded prevention providers to build capacity and resources to help communities facilitate partnerships and collaborations focusing on effective prevention strategies and programs that address alcohol, other drug abuse and problem gambling in a multi-county area. The resource centers will also serve as a key component in the transfer of knowledge to communities and prevention providers on current prevention science.

3270 - NY NY III: Post-Treatment Housing

Housing opportunities combined with appropriate supportive services that meet the needs of homeless individuals who have completed some course of treatment for a substance abuse disorder and are at risk of street homelessness or sheltered homelessness and who need long-term supportive housing to sustain sobriety and to achieve independent living.

3370 - NY NY III: Housing For Persons At Risk For Homelessness

Housing opportunities combined with appropriate supportive services that meet the needs of homeless individuals with a substance abuse disorder that is a primary barrier to independent living and who also have a disabling clinical condition.

3470 - Permanent Supported Housing

Housing opportunities combined with appropriate supportive services that meet the needs of individuals who have completed a course of treatment for a substance abuse disorder and are at risk of street homelessness or sheltered homelessness and who need transitional supportive housing to sustain sobriety and achieve independent living. Congregate Housing is a single building for the purposes of providing apartments of a size and character that conforms to applicable state and city laws and regulations. The supportive housing units may be part of a larger building. Scattered Site Housing is apartments for the purposes of housing and serving the tenants who are the recipients of this program.

3500 - Medically Managed Detoxification

As defined in Part 816 of OASAS' regulations, medically managed detoxification services are designed for patients who are acutely ill from alcohol-related and/or substance-related addictions or dependence, including the need for medical management of persons with severe withdrawal or risk of severe withdrawal symptoms, and may include individuals with or at risk of acute physical or psychiatric comorbid condition. Individuals who are incapacitated to a degree which requires emergency admission, may be admitted to such facility in accordance with Section 21.09 or 23.02 of the Mental Hygiene Law. Such services shall not be provided on an ambulatory basis.

3510 - Medically Monitored Withdrawal

As defined in Part 816 of OASAS' regulations, medically monitored withdrawal services can be provided by any provider of services certified by OASAS to provide inpatient or residential chemical dependence services and are designed for persons intoxicated by alcohol and/or substances, or who are suffering from mild withdrawal coupled with situational crisis, or who are unable to abstain with an absence of past withdrawal complications, or who are individuals in danger of relapse. Such services do not require

physician direction or direct supervision by a physician, and are designed to provide a safe environment in which a person may complete withdrawal and secure a referral to the next level of care.

3520 - Medically Supervised Outpatient

These programs assist individuals who suffer from chemical abuse or dependence and their family members and/or significant others through group and individual counseling; education about, orientation to, and opportunity for participation in, relevant and available self-help groups; alcohol and substance abuse disease awareness and relapse prevention; HIV and other communicable diseases, education, risk assessment, supportive counseling and referral; and family treatment. In addition, social and health care services, skill development in accessing community services, activity therapies, information and education about nutritional requirements, and vocational and educational evaluation must be available either directly or through written agreements. Procedures are provided according to an individualized assessment and treatment plan. This service mandates that medical staff be part of the multi-disciplinary team and the designation of a Medical Director, which provides for medical oversight and involvement in the provision of outpatient services. These services are Medicaid eligible providing other standards pertaining to fee-for-service Medicaid are met.

3528 - Enhanced Medically Supervised Outpatient

3530 - Outpatient Rehabilitation Services

This service level is designed to serve more chronic individuals who have inadequate support systems, and either have substantial deficits in functional skills or have health care needs requiring attention or monitoring by health care staff. These programs provide social and health care services, skill development in accessing community services, activity therapies, information and education about nutritional requirements, and vocational and educational evaluation. Clients initially receive these procedures five days a week for at least four hours per day. There is a richer staff to client ratio for these services compared to other outpatient levels and these services are required to have a half-time staff person qualified in providing recreation and/or occupational services as assistant or registered nurse. Like=half-time nurse practitioner, physician medically supervised outpatient, outpatient rehabilitation services, mandate that medical staff be part of the multi-disciplinary team and the designation of a Medical Director, which provides for medical oversight and involvement in the provision of outpatient services. These services are Medicaid eligible providing other standards pertaining to fee-for-service Medicaid are met.

3538 - Enhanced Outpatient Rehabilitation Services

3550 - Chemical Dependence Inpatient Rehabilitation Services

An intensive program for clients requiring evaluation and treatment services in a highly structured setting. The length of stay is determined on the basis of client characteristics and usually ranges from 21 to 60 days. The program is medically supported and should also provide chemical dependence education and counseling services for significant others of chemical dependence clients. This type of program is appropriate for clients who need concentrated, therapeutic service prior to community residence, or as their sole form of

residential care. Generally, inpatient rehabilitation programs should be freestanding facilities. They may also be operated as special discrete units in a general hospital or hospital for mental illness, organized separately from acute care services.

3551 - Residential Rehabilitation Services for Youth (RRSY)

As defined in Part 817 of OASAS' regulations, residential rehabilitation services for youth is an inpatient treatment program which provides active treatment to adolescents in need of chemical dependence services. Active treatment is provided through a multi-disciplinary team. In an RRSY program, the multi-disciplinary team defined in Part 800 of OASAS' regulations is expanded to include (1) a psychiatrist, or a physician and a clinical psychologist and (2) a CSW or an RN or an Occupational Therapist.

Admission to an RRSY is based on a Pre-Admission Certification by an Independent Pre-Admission Certification team.

Units of Service: Patient Day.

3560 - Intensive Residential

These programs assist individuals who suffer from chemical dependence, who are unable to maintain abstinence or participate in treatment without the structure of a 24-hour/day, 7 day/week residential setting and who are not in need of acute hospital or psychiatric care or chemical dependence inpatient services. In addition to counseling, peer group counseling, supportive services, educational services, structured activity and recreation and orientation to community services, intensive residential programs provide the following, either directly or by referral: vocational procedures such as vocational assessment, job skills training and employment readiness training; parenting, personal, social and community living skills training including personal hygiene and leisure activities. These services provide a minimum of 40 hours/week of procedures within a therapeutic milieu.

3570 - Community Residential

These services provide a structural therapeutic milieu while residents are concurrently enrolled in an outpatient chemical dependence service which provides addiction counseling. Community residential services provide the following procedures either directly or by referral: vocational procedures such as vocational assessment, job skills training and employment readiness training; parenting, personal, social and community living skills training including personal hygiene and leisure activities. Individuals appropriate for this level of care include persons who are homeless or whose living environment is not conducive to recovery and maintaining abstinence.

3580 - Supportive Living

A community residence program providing continued congregate living to chronic alcoholic persons with a poor prognosis for independent living. Clients will be referred from halfway houses or recovery homes. The facility will consist of a group home or apartment without regular on-site staffing. This type of setting provides fellowship and peer group support for the maintenance of recovery for clients who do not otherwise have the opportunity to live in an environment supportive of recovery. Length of stay is long term and can be indefinite.

3810 - Managed Addiction Treatment Services (MATS)

Managed Addiction Treatment Services (MATS) is a program that provides case management services to Medicaid eligible recipients of chemical dependence services. The goal of MATS is to assure effective and appropriate access to needed treatment services and positive treatment outcomes for Medicaid recipients. Services may include linking recipients with appropriate services, case-specific advocacy and monitoring access to and utilization of services to avoid duplicative services. Case management services will be provided by the Local Governmental Unit through a partnership between the local mental hygiene agency and the local department of social services (LDSS).

Units of Service: To be determined.

4030 - Residential Chemical Dependency Program for Youth (Short-Term)

A voluntary intensive inpatient rehabilitation program for youthful clients who require concentrated therapeutic services in a drug-free setting. It provides active treatment through multi-disciplinary clinical services designed to achieve dependence-free discharge to non-residential settings. The program is part of a continuum of care for chemically dependent youth and may be operated by public, private not-for-profit or proprietary sponsors. The planned length of stay is 45 to 60 days.

4045 - Specialized Services Substance Abuse Programs

Specialized chemical dependence services not defined in other regulations that must be provided in accord with the OASAS rules, regulations, and requirements.

4060 - Residential Chemically Dependency Program for Youth (Long-Term)

A voluntary residential recovery home program for youthful clients in a drug-free setting. It provides residential therapeutic care to those youths with a history of chronic chemical dependency. The program is part of a continuum of care for chemically dependent youths and may be operated by public, private not-for-profit or proprietary sponsors. The planned length of stay is more than 60 days but does not exceed 15 months.

4071 - Intake, Outreach & Referral Units

Specialized chemical dependence related support services to provide intake, outreach, and referral.

4072 - Vocational Rehabilitation

Vocational rehabilitation is a process that prepares people for employment by helping them choose a vocational role and function that is consistent with their abilities, achievements, interests, and functioning capacity. The specific goals of a vocational rehabilitation program vary with the needs of the target population. The process includes the following services: vocational testing, assessment, counseling, pre-vocational activities, training, educational services, life skills/employability referrals, job referrals and placement, and post-placement counseling and follow-up. Programs provide these vocational rehabilitation services directly or by referring the client to an appropriate resource.

4073 - Support Services – Medical/Legal/Psychological
Specialized chemical dependence related support services of medical, legal, and psychological activities.

4074 - Support Services – Educational
Specialized chemical dependence related support services to provide educational services.

4075 - Community Services
Specialized chemical dependence related support services to provide community services by program staff, such as telephone crisis counseling.

4077 - Resource
Specialized chemical dependence related support services to provide resource support, such as training.

4078 - Program Administration
Specialized chemical dependence related support services to provide program administration.

4175 - COSA (Children of Substance Abusers)
Prevention and intervention strategies focused on Children of Substance Abusers (COSAs),

4470 - AIDS Resource
Programs that provide AIDS/HIV resource services (e.g., AIDS/HIV Coordinators, staff training in AIDS/HIV issues, informational materials, intake, outreach and referral services, medical, legal and psychological services, etc.) to substance abuse programs and substance abuse program clients.

4778 - Legislative Member Item
Programs that provide chemical dependence projects and services funded by General Fund, Local Assistance Account Member Item appropriations.

5550 - Chemical Dependence Prevention Services
Activities designed to decrease risk factors and increase protective factors for substance use and abuse.

5990 - Dual Diagnosis Coordinator
Specialized chemical dependence related support services to provide coordination of care for dually diagnosed patients.

6030 - Methadone-to-Abstinence – Residential
Methadone treatment delivered in a residential setting in gradually decreasing doses to the point of abstinence, followed by continued drug-free treatment.

6040 - Methadone-to-Abstinence – Day Service
Methadone treatment delivered in a day service setting in gradually decreasing doses to the point of abstinence, followed by continued drug-free treatment.

General OMH Reporting Requirements

OMH service providers are required to report expenses and revenues for each program/site on the core and supplemental schedules of the CFR. In most cases, program/sites of the same program type are then aggregated on Schedules DMH-1, DMH-2 and DMH-3. The general program/site and program type reporting requirements are:

- Program/Site reporting on Schedules CFR-1, CFR-4, CFR-4A, OMH-1, OMH-2 and OMH-3.
- Program Type reporting on Schedules DMH-1, DMH-2, and DMH-3.

Exceptions to Program/Site Reporting (on CFR-1, CFR-4, CFR-4A, OMH-1, OMH-2 and OMH-3):

- *OMH Satellites*
  A satellite is defined as a physical extension of a program under that program's operating certificate. *Do not report these satellite programs on a site specific basis.* The expenses, revenues, and units of service will be included in the certified program.

- *OMH Start-up*
  OMH programs having a start-up component (as approved on their budget) will treat the start-up as a separate program and report revenue and expenses in the column adjacent to the program column that received the start-up funds. For OMH start-ups, enter "A0" as the program code index. Example: 6070 A0. If there are two or more start-ups for a particular program type, enter "A1" for the first occurrence, "A2" for the second occurrence, etc.

- *OMH Programs with multiple sites under the same license*
  Licensed programs are reported by program/site as designated under a specific operating certificate (i.e., for Treatment/Apartment programs (program code 7070), all apartments operating under a specific license must be reported together).

Exceptions to Program Type Reporting (on DMH-1, DMH-2 and DMH-3):

- The following programs *must* be reported by program/site throughout the CFR (including the claiming schedules): Permanent Housing Program (program code 1070), Family Based Treatment (program code 2040), Transient Housing (program code 2070), Treatment/Congregate (program code 6070), Support/Congregate (program code 6080), Community Residence, Children & Youth (program code 7050) and Community Residence, Single Room Occupancy (program code 8050), supported SRO (program code 5070).

- The following OMH licensed programs must be reported by program/site on Schedules CFR-1, CFR-4 and CFR-4A and *can* be reported by program type on Schedules DMH-2 and DMH-3: Treatment/Apartment (program code 7070) and Support/Apartment (program code 7080).

CBR vs. CFR reporting
Programs should only be reported discretely if they are operated as individual programs and are not part of a larger program. Additionally, a program reported discretely on the approved CBR must also be reported discretely on all other fiscal documents submitted to OMH and the Health Department. For example, providers may not report a case management program's expenses and revenues as a discrete program on one document, but include those expenses and revenues as part of a clinic treatment program on a different document. Refer to the next item if a program/site is reported by funding source on the CBR.

When to report program/sites by funding source
OMH program/sites may be split by funding source (i.e., reinvestment versus non-reinvestment funding) *ONLY* on the claiming schedules (DMH-2 and DMH-3) ***not*** on the cost reporting schedules (CFR-1 through CFR-6). Please refer to the software instructions on the creation of additional sites on schedules DMH-2 and DMH-3 to accommodate these multiple occurrences.

When to Index Program Codes
OMH program codes may need to be indexed in certain situations when using software. If a service provider operates more than one program/site of the same program type (i.e., two treatment/ congregate facilities), which are not aggregated by program type on the claiming schedules, the program codes must be indexed.

The program codes are indexed on approved CFR software by the use of a two digit field following the four digit program code.

> Example: A service provider operates three treatment/congregate facilities (6070). These program/sites are reported in three separate columns on the core schedules. This program type is not aggregated by program type on the claiming schedules, so these program/sites are also reported in three separate columns on Schedules DMH-1, DMH-2 and DMH-3. The program codes are indexed *throughout the CFR document* as 6070 01, 6070 02, and 6070 03.

There have been a significant number of changes to the OMH listing of Program Codes and Definitions for periods beginning 7/1/05 for NYC; 1/1/06 Upstate and Long Island. The following crosswalk is provided to identify changes you may need to accommodate on your CFR submission.

Following this alphabetic list is a numeric list of program definitions and the corresponding codes.

Program Type	Program Code
Advocacy/Support Services	1760
Affirmative Business/Industry	2340
Assertive Community Treatment (ACT) Program	0800
Assertive Community Treatment (ACT) Program Service Dollars	8810
Assisted Competitive Employment	1380

Program Type	Program Code
Blended Case Management	0820
Bridger Services	1990
C&F Clinic Plus Outreach and Screening Services (Unlicensed Program)	0790
Case Management	0810
Clinic Treatment	2100
Community Residence, Children & Youth	7050
Community Residence, Single Room Occupancy (SRO)	8050
Comprehensive PROS With Clinic	6340
Comprehensive PROS Without Clinic	7340
Compulsive Gambling Education, Assessment & Referral Services	2790
Compulsive Gambling Treatment	2780
Conference of Mental Hygiene Directors	2860
Consumer Service Dollars (Non ICM/SCM/ACT)	2820
Continuing Day Treatment	1310
Coordinated Children's Services Initiative	2990
CPEP Crisis Beds	2600
CPEP Crisis Intervention	3130
CPEP Crisis Outreach	1680
CPEP Extended Observation Beds	1920
Crisis Intervention	2680
Crisis Residence	0910
Crisis/Respite Beds	1600
Day Treatment (Children & Adolescents)	0200
Drop In Centers	1770
Enclave in Industry	1340
Family Based Treatment Program	2040
Family Care	0040
Family Support Services (Children & Family)	1650
FEMA Crisis Counseling Assistance and Training	1690
Geriatric Demo Gatekeeper	1410
Geriatric Demo Physical Health-Mental Health Integration	1420
HCBS Waiver Crisis Response	2260
HCBS Waiver Family Support	2250
HCBS Waiver Individualized Care Coordination	2230
HCBS Waiver Intensive-in-Home	2280
HCBS Waiver Respite Care	2240
HCBS Waiver Skill Building	2270
Home Based Crisis Intervention	3040
Homeless Placement Services (Non-Licensed Program)	1960
Inpatient Psychiatric Unit of a General Hospital	3010
Intensive Case Management	1810
Intensive Case Management (ICM) Services Dollars Management	2810

Program Type	Program Code
Intensive Case Management/Supportive Case Management/Blended Case Management Emergency and Non-Emergency Service Dollars	2830
Intensive Psychiatric Rehabilitation Treatment (IPRT)	2320
Limited License PROS	8340
Local Governmental Unit (LGU) Administration	0890
Local Governmental Unit (LGU) Administration - Reinvestment and Medication Grant Program (MGP) – OMH Only	0860
MICA Network	5990
Monitoring and Evaluation, CSS	0870
Multicultural Initiative	3990
Ongoing Integrated Supported Employment Services	4340
On-Site Rehabilitation	0320
Outreach	0690
Partial Hospitalization	2200
Permanent Housing Program (PHP)	1070
PROS Rehabilitation and Support Subcontract Services	9340
Psychosocial Club	0770
Recreation	0610
Residential Treatment Facility – Children & Youth	1080
Residential Treatment Facility Transition Coordinator – Community	2880
Respite Services	0650
School Program Co-located with Clinic Treatment Program	1510
School Program without Clinic	1520
Shelter Plus Care Housing (when funds flow through OMH, use 2070 when they do not)	3070
Sheltered Workshop/Satellite Sheltered Workshop	0340
Single Point of Access (SPOA)	1400
Special Legislative Grant	1190
Support Apartment	7080
Support Congregate	6080
Supported Education	5340
Supported Housing Community Services	6060
Supported Housing Rental Assistance	6050
Supported Single Room Occupancy (SP-SRO)	5070
Supportive Case Management (SCM)	6810
Teaching Family Home	4040
Transient Housing – THP, some PHP and some S+C (funds not flowing through OMH)	2070
Transition Management Services	1970
Transitional Employment Placement (TEP)	0380
Transportation	0670
Treatment Apartment	7070

Program Type	Program Code
Treatment Congregate	6070
Vocational Services (Children & Family)	1320
Work Program	3340

0040 - Family Care
(Licensed Program)

The Family Care Program provides a 24-hour supervised setting, clinical services as needed and case management services to maximize linkages with community support services to persons who no longer require inpatient care, who cannot yet function in an independent living arrangement and who have demonstrated a functional level appropriate for living in a natural family environment.

Units of Service: Count one patient day as one unit.

0200 - Day Treatment
(Licensed Program)

Day treatment services for children and adolescents provide intensive, non-residential services. The programs are characterized by a blend of mental health and education services provided in a fully integrated program. Typically, these programs include education in small classes with an emphasis on individualized instruction, individual and group counseling, family services such as family counseling, crisis intervention, interpersonal skill development and behavior modification. Children and adolescents receiving day treatment services live at home or in the community but are identified by their school district as seriously emotionally disturbed and cannot be maintained in regular classrooms.

Units of Service:
- Brief Day Treatment: One to three hours.
- Half-day visit: Three but less than five hours.
- Full day visit: Five hours or over.
- Collateral visit: At least 30 minutes.
- Home visit: At least 30 minutes.
- Crisis-visit: At least 30 minutes.
- Pre-Admission full-day visit: At least five hours.
- Pre-Admission half day visit: At least three hours but less than five hours.

Total Units of Service: Add weighted visits by category to calculate a total.

0320 - On-site Rehabilitation
(Non-Licensed Program)

The objective is to assist individuals disabled by mental illness who live in adult congregate care settings, supervised or supported living arrangements to achieve their treatment and community

living rehabilitation goals. Services include one or a combination of: (1) consumer self-help and support interventions: (2) community living; (3) academic and/or social leisure time rehabilitation training and support services. These services are typically provided either at the residential location of the resident or in the natural or provider-operated community settings which are integral to the life of the residents. These on-site rehabilitation services are provided by a team that is either located at the residential site or which functions as a mobile rehabilitation team traveling from site to site.

Units of Service:

- Brief Day Visit: less than 3 hours.
- Half-day visit: 3 but less than 5 hours.
- Full-day visit: 5 hours or more.

Total Units of Service: Add weighted visits by category to calculate a total.

0340 - Sheltered Workshop/Satellite Sheltered Workshop
(Non-Licensed Program)

The objective is to provide vocational assessment, training, and paid work in a protective and non-integrated work environment for individuals disabled by mental illness. Services are provided according to wage and hour requirements specified in the Fair Labor Standards Act administered by the Department of Labor.

Units of Service:

- Brief day visit: Less than 3 hours
- Half-day visit: 3 but less than 5 hours
- Full-day visit: 5 hours or more

Total Units of Service: Add weighted visits by category to calculate a total.

0380 - Transitional Employment Placement (TEP)
(Non-Licensed Program)

The objective is to strengthen the individual's work record and work skills toward the goal of achieving assisted or unassisted competitive employment at or above the minimum wage paid by the competitive sector employer. TEP's provide time-limited employment and on-the-job training in one or more integrated employment settings as an integral part of the individual's vocational rehabilitation growth.

- Direct staff hours: The number of staff hours spent by staff in providing case management services face-to-face or by telephone directly to Consumers or collaterals.
- Indirect staff hours: The number of staff hours spent by staff in providing case management services on behalf of Consumers other than face-to-face or by telephone directly with Consumers or collaterals.

Units of Service: Count the total number of staff hours (combine direct and indirect).

0610 – Recreation
(Non-Licensed Program)

A program of social, recreational, and leisure activities that are intellectually and interpersonally stimulating but which are not necessarily part of a goal-based program plan. Agencies which provide no other types of programs should report this service in the recreation category. Recreation activities which are part of other programs should not be reported as part of recreation programs.

Units of Service: Total the number of visits.

0650 – Respite Services
(Non-Licensed Program)

Temporary services (not beds) provided by trained staff in the consumer's place of residence or other temporary housing arrangement. Includes custodial care for a disabled person in order that primary care givers (family or legal guardian) may have relief from care responsibilities. The purpose of respite services is to provide relief to the primary care provider, allow situations to stabilize and prevent hospitalizations and/or longer term placements out of the home. Maximum Respite Care services per consumer per year are 14 days.

Units of Service: Total the staff hours spent providing respite services.

0670 – Transportation
(Non-Licensed Program)

The provision of transportation to and from facilities or resources specified in the consumer's individual treatment plan as a necessary part of his/her service for mental disability. This includes all necessary supportive services for full and effective integration of the consumer into community life.

- A consumer trip is the one-way transportation of a consumer from one place to another. For example, transportation of one consumer from home to the facility and back is counted as two trips; transportation of two consumers to and from is counted as four trips.

Units of Service: Count the number of trips.

0690 – Outreach
(Non-Licensed Program)

Outreach programs/services are intended to engage and/or assess individuals potentially in need of mental health services. Outreach programs/services are not crisis services. Examples of applicable services are socialization, recreation, light meals, and provision of information about mental health and social services. Another type of service within this program code

includes off-site, community based assessment and screening services. These services can be provided at forensic sites, a consumer's home, other residential settings, including homeless shelters, and the streets.

This program code should **not** be used for services that are provided by a licensed outpatient program. For unlicensed crisis type services use program code 2680 Crisis Intervention.

Units of Service: Total the number of contacts.

0770 - Psychosocial Club
(Non-Licensed Program)

The objective is to assist individuals disabled by mental illness to develop or reestablish a sense of self-esteem and group affiliation, and to promote their recovery from mental illness and their reintegration into a meaningful role in community life through the provision of two or more of the following: (1) consumer self-help and empowerment interventions; (2) community living: (3) academic; (4) vocational and/or (5) social-leisure time rehabilitation, training and support services.

Units of Service: Count each consumer visit as one unit (no more than one unit of service per consumer per day unless the consumer returns for a planned evening program in which case count as two (2) units).

0790 – C&F Clinic Plus Outreach and Screening Services
(Unlicensed Program)

C&F Clinic Plus Outreach and Screening Services are conducted by designated Child and Family Clinic Plus clinics. Mental Health screening under Clinic Plus is a broad based approach to identify children and adolescents with emotional disturbances, and intervene at the earliest possible opportunity. Screenings are provided in community settings, and with the prior written consent of the child's parent or legal guardian.

This code can only be used by providers who have been designated as a Child and Family Clinic Plus provider, and who operate a licensed Clinic Treatment program serving children.

Units of Service: Count each Contact as a unit of service.

0800 - Assertive Community Treatment (ACT) Program
(Licensed Program)

ACT Teams provide mobile intensive treatment and support to people with psychiatric disabilities. The focus is on the improvement of an individual's quality of life in the community and reducing the need for inpatient care, by providing intense community-based treatment services by an interdisciplinary team of mental health professionals. Building on the successful components of the Intensive Case Management (ICM) program, the ACT program has low staff-outpatient ratios; 24-hour-a-day, seven-day-per-week availability; enrollment of consumers, and

flexible service dollars. Treatment is focused on individuals who have been unsuccessful in traditional forms of treatment.

Units of Service:

- Intensive Program Full Payment: Six or more face-to-face contacts per individual per month (may include 3 collateral visits) count as one unit.
- Intensive Program - Partial Payment: Between 2 and 5 face-to-face contacts per individual per month count as one unit.
- Supportive Program: 2 or more face-to-face contacts per individual per month count as one unit.

Total Units of Service: Total the number of contacts.

0810 - Case Management
(Non-Licensed Program)

Activities aimed at linking the consumer to the service system and at coordinating the various services in order to achieve a successful outcome. The objective of case management in a mental health system is continuity of care and service. Services may include linking, monitoring and case-specific advocacy.

- Linking: The process of referring or transferring a consumer to all required internal and external services that include the identification and acquisition of appropriate service resources.
- Monitoring: Observation to assure the continuity of service in accordance with the Consumer's treatment plan.
- Case-Specific Advocacy: Interceding on behalf of a consumer to assure access to services required in the individual service plan. Case management activities are expediting and coordinative in nature rather than the primary treatment services ordinarily provided by a therapist.

Case management services are provided to enrolled consumers for whom staff are assigned a continuing case management responsibility. Thus, routine referral would not be included unless the staff member making the referral retains a continuing active responsibility for the consumer throughout the system of service.

- Direct staff hours: The number of staff hours spent by staff in providing case management services face-to-face or by telephone directly to consumers or collaterals.
- Indirect staff hours: The number of staff hours spent by staff in providing case management services on behalf of consumers other than face-to-face or by telephone directly with consumers or collaterals.

Units of Service: Count the total number of staff hours (combine direct and indirect).

Note: Use Program Code 2100 (Clinic Treatment) if the Case Management services are affiliated with a licensed Clinic Treatment program. Please refer to Codes 1810, 6810 and 0820 for more Case Management service codes for applicability.

0820 – Blended Case Management
(Non-Licensed Program)

This program will facilitate a team approach to case management services by combining the caseloads of multiple Intensive Case Managers (ICMs) and/or Supportive Case Managers (SCMs).

Units of Service: Two fifteen minute minimum face-to-face contacts per individual, per month (may include 1 collateral visit for children per month) counted as one unit. Count the total number of contacts.

0860 - Local Governmental Unit (LGU) Administration - Reinvestment and Medication Grant Program (MGP)
(Non-Licensed Program)

This program category includes all local government costs related to administering mental hygiene services that are provided by a local government or by voluntary agency pursuant to a contract with a local governmental unit. This program category can also be used for services funded under the Community Reinvestment Act (RIV) and for Kendra's Medication Grant Program. This program can only be used with fund source codes 170D, 200, 300 and 400. Agency administrative costs allocated to the operating costs of this program via the Ratio Value allocation methodology are redistributed to other OMH programs in the CFR.

Units of Service: Not applicable.

0870 - Monitoring and Evaluation (CSS)
(Non-Licensed Program)

Funds provided for monitoring and evaluation activities associated with the program and fiscal management of the CSS program provided by a Core Service Agency and those costs incurred by the Local Government Unit for the Administration of the CSS program in those counties which have opted to administer the combined CSS/620 funding streams. Agency administrative costs allocated to the operating costs of this program via the Ratio Value allocation methodology are redistributed to other OMH programs in the CFR.

Units of Service: Not applicable.

0890 - Local Governmental Unit (LGU) Administration
(Non-Licensed Program)

The Local Governmental Unit is defined in Article 41 of the Mental Hygiene Law. This program category includes all local government costs related to administering mental hygiene services

that are provided by a local government or by voluntary agency pursuant to a contract with a local governmental unit. This program does not include agency administration and can only be used with fund source code 001A.

Units of Service: Not applicable.

0910 – Crisis Residence
(Licensed Program)

A licensed residential (24 hours/day) stabilization program, which provides services for acute symptom reduction and the restoration of patients to pre-crisis level of functioning. These programs are time limited for persons until they achieve stabilization (generally up to 30 days). Crisis residences serve persons experiencing rapid or sudden deterioration of social and personal conditions such that they are clinically at risk of hospitalization but may be treated in this alternative setting.

This program is licensed for adults as defined in 14NYCRR589 and for children and adolescents as defined in 14NYCRR594.

Units of Service*:* One resident day.

1070 - Permanent Housing Program (PHP)
(Non-Licensed Program)

A federally-funded program of housing assistance specifically targeted to the homeless mentally ill. Funds may be used for: the acquisition and/or rehabilitation of a program site; operating expenses; support services; and administrative expenses. These funds flow to OMH from the federal Department of Housing and Urban Development. OMH will then advance these funds to the not-for-profit provider agency via the existing general fund contract. OMH requires that any not-for-profit agency in receipt of these funds must report the funds in a separate program column with programs indexed if necessary. New Permanent Housing Grants are made for five years at a time. The term for renewal grants varies from one to three years. In cases where the funds go directly to the provider and do not flow through OMH (after federal year 1992), see program code 2070).

Units of Service*:* Not applicable.

1080 - Residential Treatment Facility - Children and Youth
(Licensed Program)

Residential Treatment Facilities (RTF's) provide fully-integrated mental health treatment services to seriously emotionally disturbed children and youth between the ages of five and 21 years of age. These services are provided in 14-61 bed facilities which are certified by both the Office of Mental Health (OMH) and the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) or Council on Accreditation (COA). RTF's are less intensively staffed than inpatient units, but provide a much higher level of services and staffing than community

residences, Office of Children and Family Services (formerly the Department of Social Services) group homes, and/or child care institutions.

Units of Service*:* Count one patient day as one unit.

1190 - Special Legislative Grants
(Non-Licensed Program)

Specific grants funded as a result of legislative member support, targeted for a particular purpose.

Units of Service*:* Not applicable.

1310 - Continuing Day Treatment
(Licensed Program)

A continuing day treatment program shall provide active treatment and rehabilitation designed to maintain or enhance current levels of functioning and skills, to maintain community living and to develop self-awareness and self-esteem through the exploration and development of patient strengths and interests. A continuing day treatment program shall provide the following services: assessment and treatment planning, discharge planning, medication therapy, medication education, case management, health screening and referral, psychiatric rehabilitation readiness development, psychiatric rehabilitation readiness determination and referral and symptom management. The following additional services may also be provided: supportive skills training, activity therapy, verbal therapy, crisis intervention services and clinical support services.

Units of Service:

- Regular: shall be at least one hour and up to five hours
- Collateral: shall be at least 30 minutes but not more than 120 minutes.
- Group Collateral: shall be at least one hour and up to two hours.

Count the total number of service hours.

1320 - Vocational Services Children and Family
(Non-Licensed Program)

The Vocational Program for Adolescents was designed to provide work training and clinical support services for those older adolescents with poor academic performance and social adjustment in regular day treatment programs. The program identifies 5 goals on which to focus:

- Goal 1: Help youths identify problem areas and learn ongoing coping skills (i.e., involvement in support groups, recognizing need for relaxation and medication management);
- Goal 2: Provide Vocational Assessment and on-the-job training and experience;
- Goal 3: Improve Social Skills;
- Goal 4: Improve Educational Functions;

- Goal 5: Provide Family Education and Support.

Units of Service: Count the number of daily staff visits.

1340 - Enclave in Industry
(Non-Licensed Program)

The objective is to provide vocational assessment, training, and transitional or long term paid work for individuals with severe disabilities in an integrated employment environment. An enclave consists of a small group of approximately five to eight individuals who work in an industrial or other economic enterprise either as individuals or as a crew. Individuals in enclaves are provided with training, supervision and ongoing support by a job coach/supervisor assigned to the work site by the rehabilitation service agency.

- Direct staff hours: The number of staff hours spent by staff in providing case management services face-to-face or by telephone directly to consumers or collaterals.
- Indirect staff hours: The number of staff hours spent by staff in providing case management services on behalf of consumers other than face-to-face or by telephone directly with consumers or collaterals.

Units of Service: Count the total number of staff hours (combine direct and indirect).

1380 - Assisted Competitive Employment (ACE)
(Non-Licensed Program)

The objective is to assist individuals in choosing, finding, and maintaining satisfying jobs in the competitive employment market at minimum wage or higher. When appropriate, ACE provides these individuals with job related skills training as well as long-term supervision and support services, both at the work site and off-site.

- Direct staff hours: The number of staff hours spent by staff in providing case management services face-to-face or by telephone directly to consumers or collaterals.
- Indirect staff hours: The number of staff hours spent by staff in providing case management services on behalf of consumers other than face-to-face or by telephone directly with consumers or collaterals.

Units of Service: Count the total number of staff hours (combine direct and indirect).

1400 Single Point Of Access (SPOA)
(Non-Licensed Program)

A SPOA is a process, *led by a SPOA Coordinator*, that helps Local Governmental Units achieve community based mental health systems that are cohesive and well coordinated in order to serve those individuals most in need of services. There are three types of SPOAs - Children's, Adult Case Management and Adult Housing. The SPOA process provides for the identification of individuals most in need of services, and manages service access and utilization.

This program code should not be used for services that are provided by a licensed out-patient program.

Units of Service: Not applicable.

1410 – Geriatric Demo Gatekeeper
(Non-Licensed Program)

The Gatekeeper Program is designed to proactively identify at-risk older adults in the community who are not connected to the service delivery system. Gatekeepers are non-traditional referral sources who come into contact with older adults through their everyday work activities. They are specifically trained to look for signs and symptoms that may indicate the older adults before a crisis occurs. Upon identification of an older adult in need, a trained Gatekeeper makes a phone call to trained staff which initiates the individual's assessment and a variety of in-home supportive services. The program is designed to keep at-risk seniors in their own homes, and prevent premature out-of-home placement. This program code should not be used for services provided by a licensed outpatient program, or for services provided by another active OMH funded program.

Units of Service: Count the total number of contacts.

1420 – Geriatric Demo Physical Health-Mental Health Integration
(Non-Licensed Program)

The Physical Health-Mental Health Integration Program is designed to increase coordination and collaboration between and among physical health and mental health providers. The two integrated care models to be used in this demonstration are 1) the co-location of mental health specialists within primary care settings and 2) improved collaboration between separate providers. Older adults benefit from the increased convenience and coordination of mental and medical disorders. This program code should not be used for services provided by a licensed outpatient program, or for services provided by another active OMH funded program.

Units of Service: Visits

1510 - School Program Co-located with Clinic Treatment Program
(Non-Licensed Program if reported under this code)

Services provided to children and adolescents with emotional/behavioral needs in a school setting in which a satellite clinic is located, as well as related supports provided to families and school staff. Services are in addition to those provided under the Clinic Treatment license, and can be provided to students not enrolled in the Clinic Treatment program. Program staff are generally also employees of the clinic and in school on a fulltime basis or, at minimum, half-time basis. Family support staff may be employees of a local family support organization with which the program contracts. Services may be stand alone or, when the student is enrolled in the co-located clinic treatment program, coordinated with clinic treatment services. Program services

include observation and assessment of children and adolescents for the purpose of determining need for mental health services; brief intervention (planned and unplanned); crisis intervention; group interventions; consultation with school staff and families; referrals to and coordination of services with other in-school or community-based providers; participation on school intervention team, Committee on Special Education, teacher or grade level teams, and other school committees dealing with the safety, health and well being of children and adolescents; collaboration with school health and social work staff; support groups for families and school faculty; classroom presentations; participation in parent/teacher conferences; participation in school events, such as parent orientations and health fairs; after school programming, and other related activities.

This program cannot be used to report expenses or revenues associated with services provided by the licensed Clinic Treatment Program (2100).

Units of Service: Total the number of staff hours.

1520 - School Program without Clinic
(Non-Licensed Program)

Services provided to children and adolescents with emotional/behavioral needs in a school setting with no onsite mental health clinic, as well as related supports provided to families and school staff. Program staff are generally in school on a full-time basis or, at minimum, half-time basis. Family support services may be provided by a local family support organization with which the program contracts. Program services include observation and assessment of children and adolescents for the purpose of determining need for mental health services; brief intervention (planned and unplanned); crisis intervention; group interventions; consultation with school staff and families; referrals to and coordination of services with other in-school or community-based providers; participation on school intervention team, Committee on Special Education, teacher or grade level teams, and other school committees dealing with the safety, health and well being of children and adolescents; collaboration with school health and social work staff; support groups for families and school faculty; classroom presentations; participation in parent/teacher conferences; participation in school events, such as parent orientations and health fairs; after school programming, and other related activities.

Units of Service: Total the number of staff hours.

1600 – Crisis/Respite Beds
(Non-Licensed Program)

A non-licensed residential program, or dedicated beds in a licensed program, which provide consumers a homelike environment with room, board and supervision in cases where individuals must be removed temporarily from their usual residence.

Units of Service: One resident day.

1650 - Family Support Services (Children and Family)

(Non-Licensed Program)

Family support programs provide an array of formal and informal services to support and empower families with children and adolescents having serious emotional disturbances. The goal of family support is to reduce family stress and enhance each family's ability to care for their child. To do this, family support programs operate on the principles of individualized care and recognizing every child and family is unique in their strengths and needs. Connecting family members to other families with children with serious emotional problems helps families to feel less isolated and identify their own strengths.

Family support programs ideally provide the following four core services: family/peer support, respite, advocacy, and skill building/educational opportunities.

Units of Service: Count the number of paid staff hours.

1680 – CPEP Crisis Outreach
(Non-Licensed Program - Associated with a Licensed CPEP Program)

A mobile crisis intervention component of the CPEP offering crisis outreach and interim crisis service visits to individuals outside an emergency room setting, in the community in natural (e.g. homes), structured (e.g., residential programs), or controlled (e.g., instructional) environments. Crisis outreach service visits are emergency mental health services provided outside an emergency room which include clinical assessment and crisis intervention treatment. Interim crisis service visits are mental health services provided to individuals who are released from a CPEP for the purpose of facilitating the individual's community tenure while waiting for the first post-CPEP visit with a community-based mental health provider.

CPEP crisis outreach and interim crisis service visits are Medicaid reimbursable.

This program is one of four program components which, when provided together, form the OMH licensed Comprehensive Psychiatric Emergency Program (CPEP). The other program components of the CPEP are: CPEP Crisis Intervention (3130), CPEP Extended Observation Beds (1920) and CPEP Crisis Beds (2600).

Units of Service:
- Crisis Outreach Visit
- Interim Crisis Visit.
- Count the total number of visits.

1690 – FEMA Crisis Counseling Assistance and Training
(Non-Licensed Program)

A program to provide individual and/or group treatment procedures which are designed to alleviate the mental and emotional crises and their subsequent psychological and behavioral conditions resulting from major disaster or its aftermath. Funded through Federal Emergency

Management Agency (FEMA). Agency administrative costs allocated to the operating costs of this program via the Ratio Value allocation methodology are redistributed to other OMH programs in the CFR.

Units of Service: Not applicable

1760 – Advocacy/Support Services
(Non-Licensed Program)

Advocacy/support services may be individual advocacy or systems advocacy (or a combination of both). Examples are warm lines, hot lines, teaching daily living skills, providing representative payee services, and training in any aspect of mental health services.

Individual advocacy assists consumers in protecting and promoting their rights, resolving complaints and grievances, and accessing services and supports of their choice.

Systems advocacy represent the concerns of a class of consumers by identifying patterns of problems and complaints and working with program or system administrators to resolve or eliminate these problems on a systemic, rather than individual basis.

Units of Service: Count the total number of contacts.

1770 - Drop-In Center
(Non-Licensed Program)

The objective of a Drop-In Center program is to identify and engage persons who may choose not to participate in more structured programs or who might not otherwise avail themselves of mental health services, and to provide services and supports in a manner which these individuals would accept. These programs are low demand, flexible and relatively unstructured, and responsive to individual need and circumstance.

Units of Service: Count the total number of units. Count each consumer visit as one unit (no more than one unit of service per consumer, per day, unless the consumer returns for a planned evening program, in which case, count as two (2) units).

1810 - Intensive Case Management
(Non-Licensed Program)

In addition to the program description for Case Management (Code 0810), ICM services are services which are operated under a fidelity structure defined in 18 NYCRR, Section 505 and a memorandum of understanding between OMH and the NYS Department of Health. Federal Individuals with Disabilities Education Act Funds

Units of Service: Four or more 15 minute minimum face-to-face contacts per individual per month (may include 1 collateral visit for children per month) count as one unit. *Note:* If the service provider chooses the “Flexible ICM Model” as defined in Section 8 of the New Initiative

Guidelines, a minimum of two (2) 15 minute minimum face-to-face contacts per individual, per month count as one unit.

Count the number of total contacts.

1920 – CPEP Extended Observation Beds
(Non-Licensed Program - Associated with a Licensed CPEP Program)

Beds operated by the Comprehensive Psychiatric Emergency Program which are usually located in or adjacent to the CPEP emergency room, are available 24 hours per day, seven days per week to provide extended assessment and evaluation as well as a safe and comfortable environment for up to 72 hours for persons, who in the opinion of the examining physicians, require extensive evaluation, assessment, or stabilization of their acute psychiatric symptoms. Extended observation bed services are reimbursed at the inpatient psychiatric rate of the hospital where the CPEP is located.

This program is one of four program components which, when provided together, form the OMH licensed Comprehensive Psychiatric Emergency Program (CPEP). The other program components of the CPEP are: CPEP Crisis Intervention (3130), CPEP Crisis Outreach (1680) and CPEP Crisis Beds (2600).

Units of Service: One (psychiatric) inpatient day.

1960 – Homeless Placement Services
(Non-Licensed Program)

Homeless placement services are intended to serve street homeless individuals who, upon assessment and evaluation, have an Axis I mental health diagnosis. The objective of homeless placement services is to identify, engage, assess and provide treatment and housing placement services in order to promote recovery and reintegration into meaningful community life through the provision of the following continuum of services: psychiatric and medical assessment/evaluation, assistance with entitlement benefit applications, as appropriate, mental health and substance abuse treatment services, transitional housing placement and/or permanent supportive housing placement.

Units of Service:

Cluster 1
a. Completion of Psycho Social summary
b. Completion of Psychiatric Evaluation
c. PPD Test Performed

For each item completed for each individual – Count as One Unit of Service

Cluster 2:
a. Completion of Public Assistance and/or SSI Application
b. Completion of (Medicaid) Application

For each item completed for each individual – Count as Two Units of Service

Cluster 3:

a. Enrollment in Mental Hygiene Services
For each enrollment for each individual – Count as Three Units of Service

Cluster 4:

a. Placement in Transitional Housing
For each individual placed in Transitional Housing – Count as Five Units of Service

Cluster 5:

a. Placement in Permanent Supportive Housing
For each individual placed in Permanent Supportive Housing – Count as Ten Units of Service

1970 – Transition Management (TM) Services
(Non-Licensed Program)

Transition Management Services (discharge planning) programs provide support for improved community service linkages and timely filing of Medicaid applications for seriously and persistently mentally ill (SPMI) consumers being released from local correctional facilities. The TM focus will be in obtaining post-release services for these consumers. TM can only be used with funding source code 170B.

Units of Service*:* The number of staff hours.

1990 – Bridger Services
(Non-Licensed Program)

Bridger Services are targeted to serve individuals that are transferring from one level of mental health service to a less restrictive mental health service. The services provide supports to link consumers to appropriate community services and to ease their transition.

Units of Service: The number of staff hours.

2040 - Family Based Treatment Program
(Licensed Program)

The Family Based Treatment Program (FBTP) treats children and adolescents who are seriously emotionally disturbed within a home environment that is caring, nurturing and therapeutic. The program employs professional parents who are extensively trained and supervised. Parents function within a well-structured system that provides respite and other types of support; additionally, they are well paid in recognition of the high levels of responsibility and expectations placed on them by the model. Under the current FBTP initiative, a single provider agency contracts with OMH to provide up to 40 homes. Each home is headed by professional parents. One family specialist is provided for each for each five professional parent

couples and a respite couple to provide training, support, advocacy and supervision. The grouping of one respite couple and five professional families with one professional staff person forms the "cluster" which is the primary arena for providing professional parent supports, sharing child care data and experiences, and training.

Children served in the FBT Program are between the ages of five and 18, with the target population under 12 years of age. The children exhibit a variety of serious emotional problems.

Children are referred directly to the program by a variety of sources that include psychiatric inpatient programs, Residential Treatment Facilities (RTF's), community agencies and parents.

This is a type of Licensed Housing/Community Residential program for children and adolescents as defined in 14NYCRR594.

Units of Service: Count one resident day as one unit.

2070 - Transient Housing (THP, Some PHP and some S+C)
(Non-Licensed Program)

Housing and Urban Development (HUD) funds - Several federally funded programs contribute housing assistance specifically targeted to the homeless mentally ill. When funds do not flow through OMH, but are sent directly to the provider, the funds are reported under this program code and funding code 090 (non-funded) on the DMH-3. Federal Programs which fall into this category are Transitional Housing Program (THP),
Supported Housing Demonstration Program (SHDP), and some Shelter Plus Care grants. Funds may be used for: the acquisition and/or rehabilitation of a program site; operating expenses; support services; and administrative expenses. These funds flow directly to the not-for-profit provider agencies from the federal Department of Housing and Urban Development. Nonetheless, OMH requires that any not-for-profit agency in receipt of these funds report the funds in a separate program column with the program code indexed if necessary. These grants are made for five years at a time.

Units of Service: Not applicable.

2100 - Clinic Treatment
(Licensed Program)

A clinic treatment program shall provide treatment designed to reduce symptoms, to improve patient functioning and to provide ongoing support.

A clinic treatment program for adults shall provide the following services: assessment and treatment planning, health screening and referral, discharge planning, verbal therapy, medication therapy, medication education, symptom management and psychiatric rehabilitation readiness determination. The following additional services may also be provided: case management, crisis intervention services, clinical support services and family treatment services.

A clinic treatment program for children shall provide the following services: assessment and treatment planning, verbal therapy, symptom management, health screening and referral, medication therapy, medication education, clinical support services and discharge planning. The following additional services may also be provided: case management, crisis intervention services and family treatment services.

- Brief visit: Shall be reimbursed for services of at least 15 minutes in duration but not more than 29 minutes of face-to-face interaction between one consumer and one therapist
- Regular visit: Shall be reimbursed for services of at least 30 minutes in duration of face-to-face interaction between one consumer and one therapist
- Crisis visit: Shall be reimbursed for services of at least 30 minutes in duration of face-to-face interaction between one consumer and one therapist
- Group therapy visits: Shall be reimbursed for services of at least 60 minutes duration provided to from 2 to 12 consumers and a therapist(s)
- Collateral visit: Shall be reimbursed for:
  - Clinical support services of at least 30 minutes in duration of face-to-face interaction between one or more collaterals and one therapist with or without a consumer; or
  - Family treatment services of at least 30 minutes in duration of face-to-face interaction among all of the following: a consumer, one or more family members, and a therapist.

    Group collateral visit: shall be reimbursed for:
    - Clinical support services, as defined in Section 587.4(c) (5), of at least 60 minutes in duration but not more than 2 hours and shall represent services to more than one consumer and/or his or her collaterals. Such visits need not include consumers but shall not include more than 12 collaterals and/or consumers in a face-to-face interaction with a therapist for which reimbursement is claimed. Such limitation does not preclude the non-reimbursed participation of additional persons in the group session but such participation shall not be separately reimbursed; or
    - Family treatment services of at least 60 minutes in duration but not more than 2 hours and shall include services to more than one consumer. For each consumer participant, at least one family member shall participate. However, only one group collateral bill per consumer is allowed per day. Such visits shall not include more than 12 participants, including consumers and family members, for which reimbursement is claimed. Such limitation does not preclude the non-reimbursed participation of additional persons in the group session.
- Family visit: Shall be reimbursed for family treatment services, as defined in Section 587.4(c)(11), of at least 60 minutes in duration of face-to-face interaction between one consumer, one or more of his or her family members, and one therapist. For purposes of billing family visits which meet these criteria, providers shall bill one regular visit and one collateral visit.

Total Units of Service: Add weighted visits by category to calculate a total.

2200 - Partial Hospitalization
(Licensed Program)

A partial hospitalization program shall provide active treatment designed to stabilize and ameliorate acute symptoms, to serve as an alternative to inpatient hospitalization, or to reduce the length of a hospital stay within a medically supervised program. A partial hospitalization program shall provide the following services: assessment and treatment planning, health screening and referral, symptom management, medication therapy, medication education, verbal therapy, case management, psychiatric rehabilitation readiness determination and referral, crisis intervention services, activity therapy, discharge planning and clinical support services.

Units of Service:

- Regular: shall be at least four hours and not more than seven hours;
- Collateral: shall be at least 30 minutes and not more than 120 minutes;
- Group Collateral: shall be at least one hour but may be up to two hours in duration.
- Crisis: shall be at least one hour but up to seven hours. In addition, pre-admission visits of at least one hour but up to three hours are allowable. These visits will be counted as crisis visits.

Total Units of Service: Add total service hours to calculate a total.

2230 – HCBS Waiver Individualized Care Coordination
(Non-Licensed Program)

Services that include the components of intake and screening, assessment of needs, service plan development, linking, advocacy, monitoring, discharge planning and consultation.

Units of Service: Total enrollee months, i.e. the 12 month total of each monthly census number (in months and half months) rounded to the next whole month.

2240 – HCBS Waiver Respite Care
(Non-Licensed Program)

A service that provides a needed break for the family and the child to ease the stress at home and improve family harmony. It may be provided on a planned or emergency basis either in home or out of home by trained respite workers.

Units of Service: Total either staff hours or per diem.

2250 – HCBS Waiver Family Support
(Non-Licensed Program)

Activities designed to enhance the ability of the child to function as part of a family unit and to increase the family's ability to care for the child in the home

Units of Service: Total staff hours.

2260 – HCBS Waiver Crisis Response
(Non-Licensed Program)

Activities aimed at stabilizing occurrence of child/family crises where they arise.

Units of Service: Total staff hours**.**

2270 – HCBS Waiver Skill Building
(Non-Licensed Program)

Activities designed to assist the child in acquiring, developing and accessing functional skills and supports - both social and environmental - needed to function more successfully in the community**.**

Units of Service: Total staff hours**.**

2280 – HCBS Waiver Intensive-in-Home
(Non-Licensed Program)

Ongoing activities aimed at providing intensive interventions in the home when a crisis response service is not enough.

Units of Service: Total staff hours**.**

2320 - Intensive Psychiatric Rehabilitation Treatment (IPRT)
(Licensed Program)

An intensive psychiatric rehabilitation treatment program is time-limited, with active psychiatric rehabilitation designed to assist a patient in forming and achieving mutually agreed upon goals in living, learning, working and social environments; to intervene with psychiatric rehabilitation technologies, to overcome functional disabilities and to improve environmental supports. An intensive psychiatric rehabilitation treatment program shall provide the following services: psychiatric rehabilitation readiness determination, psychiatric rehabilitation goal setting, psychiatric rehabilitation functional and resource assessment, psychiatric rehabilitation service planning, psychiatric rehabilitation skills and resource development and discharge planning.

Units of Service: Total service hours.

2340 - Affirmative Business/Industry
(Non-Licensed Program)

The objective is to provide vocational assessment, training, transitional or long-term paid employment, and support services for persons disabled by mental illness in a less restrictive/more integrated employment setting than sheltered workshops. Affirmative Business programs may include mobile contract services, small retail or wholesale outlets, and manufacturing and service oriented businesses.

Units of Service: Count the total number of consumer hours.

2600 – CPEP Crisis Beds
(Non-Licensed Program)

A residential (24 hour/day) stabilization component of the CPEP, which provides supportive services for acute symptom reduction and the restoration of patients to pre-crisis level of functioning. These programs are time limited (up to five days) for patients until they achieve stabilization. Crisis beds serve persons experiencing rapid or sudden deterioration of social and personal conditions such that they are clinically at risk of hospitalization but may be treated in this alternative setting. CPEP crisis bed services are *neither* funded by OMH *nor* Medicaid-reimbursable, but are purchased from the facility operating these beds.

This program is one of four program components which, when provided together, form the OMH licensed Comprehensive Psychiatric Emergency Program (CPEP). The other program components of the CPEP are: CPEP Crisis Intervention (3130), CPEP Crisis Outreach (1680) and CPEP Extended Observation Beds (1920).

Units of Service: One resident day.

2680 Crisis Intervention
(Non-Licensed Program)

Crisis intervention services, applicable to adults, children and adolescents, are intended to reduce acute symptoms and restore individuals to pre-crisis levels of functioning. Examples of where these services may be provided include emergency rooms and residential settings. Provision of services may also be provided by a mobile treatment team, generally at a consumer's residence or other natural setting (not at an in-patient or outpatient treatment setting). Examples of services are screening, assessment, stabilization, triage, and/or referral to an appropriate program or programs. This program type does not include warm lines or hot lines. Use Advocacy/Support 1760 for such services.

This program code should **not be used for services that are provided** by a licensed out-patient program.

Units of Service: Count the total staff hours.

2770 - Self Help Program
(Non-Licensed Program)

To provide rehabilitative and support activities based on the principle that people who share a common condition or experience can be of substantial assistance to each other. These programs may take the form of mutual support groups and networks, or they may be more formal self-help organizations that offer specific educational, recreational, social or other program opportunities.

- Direct staff hours: The number of staff hours spent by staff in providing case management services face-to-face or by telephone directly to consumers or collaterals.
- Indirect staff hours: The number of staff hours spent by staff in providing case management services on behalf of consumers other than face-to-face or by telephone directly with consumers or collaterals.

Units of Service: Count the number total number of staff hours (combine direct and indirect).

2780 - Compulsive Gambling Treatment
(Non-Licensed Program)

To provide outpatient treatment to compulsive gamblers designed to reduce symptoms, improve functioning and provide ongoing support. A compulsive gambling treatment program shall provide assessment and treatment planning specific to compulsive gambling, screening and referral for other problems, financial management planning, connection to self help groups for compulsive gamblers, individual, group and family therapy specific to this diagnosis and crisis intervention.

Units of Service: Count the total number of visits.

2790 - Compulsive Gambling Education, Assessment and Referral Services
(Non-Licensed Program)

To participate in the statewide public information campaign, assess the existence of compulsive gambling and make referrals and linkages to compulsive gambling treatment programs, other human services, and self help groups for compulsive gamblers.

Units of Service: Count the number of direct staff hours.

2810 – Intensive Case Management (ICM) Services Dollars Management
(Part of the Intensive Case Management Program)

Direct costs of support provided by the county or agency for contracted management expenses.

Units of Service: Not applicable.

2820 – Consumer Service Dollars (Non ICM/SCM/BCM/ACT)
(Non-Licensed Program)

Consumer Service Dollars (also known as "wrap-a-round" dollars) may be used for any service(s) that address a consumer's basic needs and assist the consumer in living, working and/or socializing in a community environment. Authorizations and the detail of use for Consumer Service Dollars must be kept and available for field audit. Providers must have internal controls in place to limit the use of these funds.

Examples of eligible expenses include: food, security deposits, lodging, respite, clothing, payment of a utility bill to prevent shut-off, medical care, transportation, crisis specialist, educational services, vocational services, leisure time activities, homemakers and escorts. A fuller description of the uses and requirements for these funds is located in the annual "Contracting and Policy Guidelines."

This definition does not apply to ICM, SCM or ACT teams. The current definition for these programs continues to apply in full. Agency administrative costs allocated to the operating costs of this program via the Ratio Value allocation methodology are redistributed to other OMH programs in the CFR.

Units of Service: Each authorization to use these funds.

2830 - Intensive Case Management/Supportive Case Management/Blended Case Management Emergency and Non-Emergency Service Dollars
(Non-Licensed Program)

Services consistent with a consumers treatment plan, designed to be flexible and responsible to current individual needs. These services may include emergency services, both immediate and not immediate. The emergency dollars aimed at meeting immediate basic needs of the consumer to include transportation, medical/dental care, shelter/respite/hotel, food/meals, clothing, escort and other. Service dollars may also include furnishings, utilities, tuition, job related costs, job coaching, education, vocational services, leisure time services and others. This program does not include agency administration. Agency administrative costs allocated to the operating costs of this program via the Ratio Value allocation methodology are redistributed to other OMH programs in the CFR.

Units of Service: Not applicable.

2860 - Conference of Mental Hygiene Directors
(Non-Licensed Program)

This program code represents funds used by the Conference of Local Mental Hygiene Directors. Agency administrative costs allocated to the operating costs of this program via the Ratio Value allocation methodology are redistributed to other OMH programs in the CFR.

Units of Service: Not applicable.

2880 - Residential Treatment Facility (RTF) Transition Coordinator – Community
(Non-Licensed Program)

This program code will be used to report approximately 25% of the costs related to RTF post-discharge case management. The NYS Office of Mental Health (OMH) is allocating resources to establish RTF Transition Coordinator staff positions to enhance the Residential Treatment Facilities' ability to ensure timely, successful discharges. RTF Transition Coordinators will maintain a relatively small caseload so that they are able to provide case management services both within the RTF facility and in the child's home community. It is expected that one RTF Transition Coordinator will be assigned for approximately every twelve RTF inpatient beds. In addition to the children occupying the RTF inpatient beds, the RTF Transition Coordinators are expected to have approximately one-fourth of their caseload in post discharge status.

Units of Service: Count the total number of consumer months – each consumer served during a month counts as one unit.

2990 - Coordinated Children's Services Initiative
(Non-Licensed Program)

The Coordinated Children's Services Initiative (CCSI) is an interagency initiative that supports localities in creating a system of care to provide structure and flexibility to ensure that children who are at risk of residential placement remain at home with their families and in their communities. The program exists at a local community level (Tier I), County level (Tier II) and State level (Tier III). These children are most often those with serious emotional disturbance. Principles are based on the Child and Adolescent Services System.

Units of Service: Count the total number of paid staff hours.

3010 – Inpatient Psychiatric Unit of a General Hospital
(Licensed Program)

A licensed, 24 hr. inpatient treatment program, that is jointly licensed by the New York State Office of Mental Health and the New York State Department of Health and operated in a medical hospital. Includes full-time medical, psychiatric and social services and around-the-clock nursing services for individuals with mental illness.

Units of Service: Count one patient day as one unit.

3040 – Home-Based Crisis Intervention
(Non-Licensed Program)

The Home-Based Crisis Intervention Program is a clinically oriented program with support services by a MSW or Psychiatric Consultant which assists families with children in crisis by providing an alternative to hospitalization. Families are helped through crisis with intense interventions and the teaching of new effective parenting skills. The overall goal of the program is to provide short-term, intensive in-home crisis intervention services to a family in crisis due to the imminent risk of their child being admitted to a psychiatric hospital. The target population for the HBCI Program is families with a child or adolescent ages 5 to 17 years of age, who are

experiencing a psychiatric crisis so severe that unless immediate, effective intervention is provided, the child will be removed from the home and admitted to a psychiatric hospital. Families referred to the program are expected to come from psychiatric emergency services.

Units of Service: Total number of paid staff hours.

3070 - Shelter Plus Care Housing
(Non-Licensed Program)

A federally-funded program of housing assistance specifically targeted to the homeless mentally ill. Funds may be used for the payment of rent stipends up to the federally-established Fair Market rent, and associated administrative expenses. OMH requires any not-for-profit agency in receipt of these funds to report the funds in a separate program column. Shelter Plus Care Grants are made for five or ten years at a time. Renewals are for one year only. This program code is used in cases where the federal funds flow through OMH. In cases where the funds do not flow through OMH, see program code 2070.

Units of Service: Not applicable.

3130 – CPEP Crisis Intervention
(Licensed Program)

This licensed, hospital-based psychiatric emergency program establishes a primary entry point to the mental health system for individuals who may be mentally ill to receive emergency observation, evaluation, care and treatment in a safe and comfortable environment. Emergency visit services include provision of triage and screening, assessment, treatment, stabilization and referral or diversion to an appropriate program. Brief emergency visits require a psychiatric diagnostic examination and may result in further CPEP evaluation or treatment activities, or discharge from the CPEP program. Full emergency visits, which result in a CPEP admission and treatment plan, must include a psychiatric diagnostic examination, psychosocial assessment and medication examination. Brief and full emergency visit services are Medicaid reimbursable.

CPEP Crisis Intervention is one of four program components which, when provided together, form the OMH licensed Comprehensive Psychiatric Emergency Program (CPEP), and the code to which the license is issued. The other program components of the CPEP are: CPEP Extended Observation Beds (1920), CPEP Crisis Outreach (1680) and CPEP Crisis Beds (2600).

Units of Service:
- Brief Emergency Visit
- Full Emergency Visit

Count the total number of visits.

3340 - Work Program
(Non-Licensed Program)

The objective is to provide vocational assessment, training and transitional or long-term paid work in institutional or community job sites for individuals disabled by mental illness. Paid by the vocational services provider.

Units of Service: Count the total number of staff hours.

3990 - Multicultural Initiatives
(Non-Licensed Program)

Funds will support activities related to the development and operation of outreach interventions in under-served communities and to address disparities based upon culture, ethnicity, age, or gender. Efforts by service providers will include the cultural and linguistic competence of their programs, management and staff.

Units of Service*:* Count the total number of staff hours.

4040 - Teaching Family Home
(Licensed Program)

The Teaching Family Homes are designed to provide individualized care to children and youth with serious emotional disturbances in a family-like, community-based environment. Specially trained parents live and work with four children and youth with serious emotional disturbances in a home-like setting. The teaching parents are responsible for the social education of the children and the implementation of a service plan developed in conjunction with the family and clinical service provider. The focus in on teaching the youth to live successfully in a family, attend school, and live productively in the community.

This is a type of Licensed Housing/Community Residential program for children and adolescents as defined in 14NYCRR594.

Units of Service: Count each resident day.

4340 - Ongoing Integrated Supported Employment Services
(Non-Licensed Program)

These funds are intended for ongoing job maintenance services including job coaching, employer consultation, and other relevant supports needed to assist an individual in maintaining a job placement. These services are intended to complement VESID time-limited supported employment services.

Units of Service: Count the total number of staff hours.

5070 - Supported Single Room Occupancy (SP-SRO)

(Non-Licensed Program)

A single-room occupancy residence which provides long term or permanent housing in a setting where residents can access the support services they require to live successfully in the community. Front desk coverage is provided 24 hours per day. Mental health service supports are provided either by SP-SRO staff or nonresidential service providers in accordance with a service plan developed jointly by the provider and resident.

Units of Service: Resident day.

5340 - Supported Education
(Non-Licensed Program)

The objective of this program is to provide mental health and rehabilitation services to individuals with a serious mental illness to assist them to develop and achieve academic goals in natural and community-based educational settings. The emerging program models for delivering this service include free-standing career development and exploration programs housed on college campuses, ongoing counseling and support by a mental health provider to enrolled students, and collaborative relationships between mental health and oncampus services to students with disabilities. Funding is to cover mental health staff and related costs.

Units of Service: Count the total number of paid staff hours.

5990 – MICA Network
(Non-Licensed Program)

The proposed network must define a service area, a target population and ensure that MICA consumers have access to housing, treatment, peer support/self-help and alcohol/substance abuse services and case management. A MICA Network would include, but not be limited to: residential capacity, case management, psycho-social capacity, enhancement of treatment capacity, self-help, peer leadership/peer specialist/peer case management, linkages with drug and alcohol providers.

Units of Service: Count the total number of paid staff hours.

6050 - Supported Housing Rental Assistance
(Non-Licensed Program)

Rental assistance is provided to residents of supported housing programs through the means of a voluntary agency-administered rent stipend mechanism. Residents are expected to contribute 30% of their income toward the cost of rent and utilities in decent, moderately priced housing in the community; the difference between the residents' contribution and the actual cost of the housing is paid directly to the landlord on behalf of the program residents.

Units of Service: Count one resident day as one unit.

6060 - Supported Housing Community Services
(Non-Licensed Program)

This includes all services provided to residents of supported housing programs by the supported housing agency, excluding rental assistance. The objective of the program is to assist individuals in locating and securing housing of their choice and in accessing the supports necessary to live successfully in the community. Services may include assistance with choosing housing, roommates, and furniture; providing financial assistance with purchasing apartment furnishings and with initial apartment/utility deposits, assistance with resolving roommate or landlord issues that may jeopardize the stability of the housing placement; and linking residents to a comprehensive community support system of case management, mental health and general health supports.

Units of Service: Count each contact as one unit.

6070 - Treatment Congregate
(Licensed Program)

A group-living designed residential program which focuses on interventions necessary to address the specific functional and behavioral deficits which prevent residents from accessing generic housing. These interventions are goal-oriented, intensive, and usually of limited duration. Staff is on-site 24 hours/day.

This is a type of Licensed Housing/Community Residential program for adults as defined in 14NYCRR595.

Units of Service: Count one resident day as one unit.

6080 - Support Congregate
(Licensed Program)

A single-site residential program which provides support designed to improve or maintain an individual's ability to live as independently as possible and eventually access generic housing. Interventions are provided consistent with the resident's desire, tolerance and capacity to participate in services. Staff is on-site 24 hours/day.

Units of Service: Count one resident day as one unit.

6340 - Comprehensive PROS with Clinic
(Licensed Program)

Personalized Recovery Oriented Services (PROS) is a comprehensive recovery oriented program for individuals with severe and persistent mental illness. The goal of the program is to integrate treatment, support and rehabilitation in a manner that facilitates the individual's recovery. Goals for individuals in the program are to: improve functioning, reduce inpatient utilization, reduce emergency services, reduce contact with the criminal justice system, increase

employment, attain higher levels of education and secure preferred housing. There are four "service components" in the program: Community Rehabilitation and Support (CRS), Intensive Rehabilitation (IR), Ongoing Rehabilitation and Support (ORS) and Clinical Treatment.

Units of Service: Count the number of direct care hours.

6810 - Supportive Case Management (SCM)
(Non-Licensed Program)

In addition to the program description for Case Management (Code 0810), SCM services are services which are operated under a fidelity structure defined in 18 NYCRR, Section 505 and a memorandum of understanding between OMH and the NYS Department of Health.

Units of Service: Count two or more face-to-face contacts per month as one unit. Report total contacts.

7050 - Community Residence, Children & Youth
(Licensed Program)

A Community Residence which provides a supervised, therapeutic environment for six to eight children or adolescents, between the ages of 5 and 18 years, that includes structured daily living activities, problem solving skills development, a behavior management system and caring consistent adult interactions. Most often, needed clinical supports for the child and family are provided by community-based services.

This is a type of Licensed Housing/Community Residential program for children and adolescents as defined in 14NYCRR594.

Units of Service: Count one resident day as one unit.

7070 - Treatment Apartment
(Licensed Program)

An apartment-based residential program which focuses on interventions necessary to address the specific functional and behavioral deficits which prevent residents from accessing generic housing. These interventions are goal-oriented, intensive, and usually of limited duration. Resident/staff contacts occur on a flexible schedule, as appropriate to the needs and desires of the resident.

This is a type of Licensed Housing/Community Residential program for adults as defined in 14NYCRR595.

Units of Service: Count one resident day as one unit.

7080 - Support Apartment
(Licensed Program)

An apartment-based residential program which provides support designed to improve or maintain an individual's ability to live as independently as possible, and eventually access generic housing. Interventions are provided consistent with the resident's desire, tolerance, and capacity to participate in services. Resident/staff contacts occur on a flexible schedule, as appropriate to the needs and desires of the resident.

This is a type of Licensed Housing/Community Residential program for adults as defined in 14NYCRR595.

Units of Service: Count one resident day as one unit.

7340 - Comprehensive PROS without Clinic
(Licensed Program)

Personalized Recovery Oriented Services (PROS) is a comprehensive recovery oriented program for individuals with severe and persistent mental illness. The goal of the program is to integrate treatment, support and rehabilitation in a manner that facilitates the individual's recovery. Goals for individuals in the program are to: improve functioning, reduce inpatient utilization, reduce emergency services, reduce contact with the criminal justice system, increase employment, attain higher levels of education and secure preferred housing. There are four "service components" in the program: Community Rehabilitation and Support (CRS), Intensive Rehabilitation (IR), Ongoing Rehabilitation and Support (ORS) and Clinical Treatment. This program does not include the optional Clinic Treatment component.

Units of Service: Direct Care Hours.

8050 - Community Residence Single Room Occupancy (CR-SRO)
(Licensed Program)

The single room occupancy residence which provides long-term housing where residents can access the support services they require to live successfully in the community and to eventually move to other residential settings. Front desk coverage is provided 24 hours per day. Mental health services are provided either by program staff or non-residential service providers, according to a plan which is developed jointly by the provider and resident. Individuals may remain in residence as long as the services provided in the program are needed.

This is a type of Licensed Housing/Community Residential program for adults as defined in 14NYCRR595.

Units of Service: Count one resident day as one unit.

8340 - Limited License PROS
(Licensed Program)

Personalized Recovery Oriented Services (PROS) is a comprehensive recovery oriented program for individuals with severe and persistent mental illness. The goal of the program is to integrate treatment, support and rehabilitation in a manner that facilitates the individual's recovery. Goals for individuals in the program are to: improve functioning, reduce inpatient utilization, reduce emergency services, reduce contact with the criminal justice system, increase employment, attain higher levels of education and secure preferred housing. A Limited License PROS program provides only Ongoing Rehabilitation and Support (ORS) and Intensive Rehabilitative Services (IR).

Units of Service: Count the total number of direct care hours**.**

8810 – Assertive Community Treatment (ACT) Program Service Dollars
(Associated with the licensed Assertive Community Treatment (ACT) program, Program Code 0800)

Individual services aimed at meeting basic needs of the consumer. These services may include emergency services as well as job coaching, education, leisure-time services and others. Agency administrative costs allocated to the operating costs of this program via the Ratio Value allocation methodology are redistributed to other OMH programs in the CFR.

Units of Service: Not applicable.

9340 - PROS Rehabilitation and Support Subcontract Services
(Non-Licensed Program)

Services provided under a contract arrangement to a licensed PROS. A PROS may find it more effective to purchase certain services from another provider. The provider of services would use this code to report the costs of providing those services and the revenue received from the PROS for the purchase of those services.

Units of Service: Count the total number of direct care hours**.**

Below is an alphabetical listing of program types and the corresponding codes. Following this alphabetic list is a numeric list of program definitions and the corresponding codes.

Program Name	Program Code
Care At Home - III	1220
Care at Home - IV & VI	2220
Case Management (Non-Medicaid)	0810
Certified Work Activity/Sheltered Workshop	0340
Classroom Education	0360
Community Residence, Part 671, Supervised Residential Habilitation	0053
Community Residence, Part 671, Supervised Room & Board	0054
Community Residence, Part 671, Supportive Residential Habilitation	1053
Community Residence, Part 671, Supportive Room & Board	1054
Consumer Transportation	0670
Crisis Intervention	0060
Day Program Services Included in the ICF/DD Reimbursement Rate (Off-Site)	6091
Day Program Services Included in the ICF/DD Reimbursement Rate (On-Site)	6090
Day Training	0330
Day Treatment – Free Standing	0200
Day Treatment – Partial	0202
Developmental Disabilities Program Council Grant	2190
Epilepsy Services	0414
Family Support Services	0150
HCBS Adaptive Technologies	0216
HCBS Assistive Supports	0221
HCBS Consolidated Supports and Services	0411
HCBS Environmental Modifications	0215
HCBS Family Education and Training	0413
HCBS Freestanding Respite	0233
HCBS Group Day Habilitation Service	0223
HCBS Individual Day Habilitation Service	0225
HCBS Live-in Caregiver	0415
HCBS Other Than Freestanding Respite	0235
HCBS Prevocational Services (Services on or after 1/1/06)	0227
HCBS Residential Habilitation, At Home	0219
HCBS Residential Habilitation Family Care	0220
HCBS Supervised IRA (Room and Board and Residential Habilitation Services)	0231
HCBS Supplemental Group Day Habilitation Service	0224
HCBS Supplemental Individual Day Habilitation Service	0226
HCBS Supported Employment	0214
HCBS Supportive IRA (Room and Board and Residential Habilitation Services)	0232
HCBS Waiver Plan of Care Support Services	0416

Program Name	Program Code
Homemaker Services	0630
ICF/DD (Over 30 Beds)	1090
ICF/DD (30 Beds or Less)	0090
Individualized Support Services	0410
Information & Referral	0750
Local Governmental Unit (LGU) Administration	0890
Medicaid Service Coordination	0229
NYC Housing Resource Consortium	0780
OMRDD Clinic Treatment Facility (Free-Standing Clinic)	0100
OMRDD Clinic Treatment Facility (Clinic Joint Venture)	0101
Options for People Through Services (NYS OPTS)	0234
Other Service Coordination (Non-Medicaid)	0222
Preschool Program	0370
Program Development Grant	0190
Recreation	0610
Residential School	0080
Shelter Plus Care Housing	3070
SOICF Sheltered Workshop/Day Training	4090
Special Legislative Grant	1190
Specialty Clinic	0120
Subcontract Services	0880
Summer Camp	0070
Supported Employment (Non-HCBS Waiver)	0390
Temporary Use Beds (TUBS) in an Intermediate Care Facility (30 Beds or Less)	0091
Temporary Use Beds (TUBS) in an Intermediate Care Facility (Over 30 Beds)	1091
Transitional Employment	0380
Traumatic Brain Injury (TBI)	1150
VOICF/DD, Day Services Contract	7090
VOICF/DD, Day Services (Not Operated by Service Provider)	7091
VOICF/DD, Day Training	5090
VOICF/DD, Day Training (Not Operated by Service Provider)	5091
VOICF/DD, School District Contract	3090
VOICF/DD, School District Contracts (Not Operated by Service Provider)	3091
VOICF/DD, Sheltered Workshop	2090
VOICF/DD, Sheltered Workshop (Not Operated by Service Provider)	2091
Voluntary Preservation Project – Formerly Known as Voluntary Operated Maintenance ,Project	1850

0053 - Community Residence Part 671 Supervised - Residential Habilitation

A facility that provides 24 hour per day responsible supervision for the habilitation or rehabilitation of developmentally disabled persons as part of an overall service delivery system. Expenses for the following may be included:

Personal Services
Vacation Leave
Mandated Fringe
Non-mandated Fringe
Transportation Related
Staff Travel
Contracted Direct Care and Clinical Care
Other OTPS
Provider Paid Equipment

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the site's Operating Certificate Number as the Program/Site Identification Number. For each Program Code 0053 column that is reported, there must be a corresponding Program Code 0054 column reported.

Note: Do not include Day Treatment/HCBS Day Habilitation To/From Transportation expense in this program. If a vehicle or staff person is assigned to this program, but is used for to/from transportation, the related expenses must be reported under Program Code 0670. See Program Code 0670 for instructions on reporting and allocating these expenses.

Units of Service: For each unit of service, count one participant day.

0054 - Community Residence Part 671 Supervised Room and Board

Room and Board. Report on a program/site specific basis.

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the site's Operating Certificate Number as the Program/Site Identification Number. For each Program Code 0054 column that is reported, there must be a corresponding Program Code 0053 column reported.

Report only those costs normally occurring in a room and board situation. Additional costs because program participants may have special needs are Res. Hab. costs.

Note: Do not include Day Treatment/HCBS Day Habilitation To/From Transportation expense in this program. If a vehicle or staff person is assigned to this program, but is used for to/from transportation, the related expenses must be reported under Program Code 0670. See Program Code 0670 for instructions on reporting and allocating these expenses.

Units of Service: For each unit of service, count one participant day.

0060 - Crisis Intervention

Those activities that assist persons with developmental disabilities and their families in dealing with specific and time-limited problems which threaten to disrupt the individual's residential situation and/or habilitation program. Such activities frequently include arranging for the provision of intensive behavioral services or other services such as respite care, health/medical services, nutrition services, counseling, legal services, and case management/service coordination.

Contract Budget consistent reporting is required for this program. The same number of columns use on the Consolidated Budget Report must be used on the CFR so that reporting is consistent.

The Program/Site Identification Number is created by using the first four digits of the Agency Code and the last three digits of the Program Code. Where more than one column will be created for this Program Code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: One hour equals one unit of service.

0070 - Summer Camp

A program certified by the Department of Health in accordance with sub-part 7-2 of Chapter 1 of the State Sanitary Code (Title X NYCRR) which provides overnight accommodations for periods of occupancy of more than 48 continuous hours. Such camps provide for the physical needs of campers and also implement a program of organized activities for the purpose of recreation and enhancement of the intellectual, sensorimotor and effective development of the participants.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent.

The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: For each unit of service, count one participant day.

For Budget Format: Count each participant day as one day.

0080 - Residential School

A non-publicly operated residential facility or institution providing a program of 24 hour professional care and treatment for developmentally disabled persons that is certified in accordance with Part 81 of Title 14 of NYCRR.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Units of Service: For each unit of service, count one participant day.

For Budget Format: Count each participant day as one day.

0090 - Intermediate Care Facility for the Developmentally Disabled (30 beds or less)

A facility operated by or subject to certification by the Office of Mental Retardation and Developmental Disabilities with a capacity of up to 30 in accordance with the requirements of Part 681 of Title 14 NYCRR and 42 CFR 442. Such facilities provide active programming, room and board, and continuous 24 hour per day supervision. They are located within the population areas of non-developmentally disabled persons. They are not of the facility type known as developmental center or school as defined by Section 13.17 of the Mental Hygiene Law.

If this Program Code is reported, a corresponding OMRDD-1, ICF/DD Schedule of Service, must be completed.

Note: When the ICF/DD rate includes an add-on component for an ICF/DD School contract, report all expense and revenue in a discreet column as program code 3090 OR 3091 as appropriate. Add-on for ICF/DD Sheltered Workshop - use program code 2090 or 2091 as appropriate. Add-on for ICF/DD Day Training - use program code 5090 or 5091 as appropriate. When the ICF/DD rate includes funding for day program services, report all expense in a discreet column as Program Code 6090, Day Program Services Included in the ICF/DD Reimbursement Rate (On-Site) or Program Code 6091, Day Program Services Included in the ICF/DD Reimbursement Rate (Off-Site). Add-on for VOICF/DD, Day Services Contract – use program code 7090 or 7091 as appropriate.

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the site's Operating Certificate Number as the Program/Site Identification Number.

Note: Do not include Day Treatment/HCBS Day Habilitation To/From Transportation expense in this program. If a vehicle or staff person is assigned to this program, but is used for to/from transportation, the related expenses must be reported under Program Code 0670. See Program Code 0670 for instructions on reporting and allocating these expenses.

Units of Service: For each unit of service, count one participant day.

For Budget Format: Count each participant day as one day.

0091 – Temporary Use Beds (TUBS) in an Intermediate Care Facility (30 Beds or Less)

When a bed (certified or uncertified) in an ICF/DD (30 beds or less) is used as a temporary use bed, the associated revenues and expenses should be reported under this program code. (Do not report the same revenue and expense under program code 0090 – Intermediate Care Facility (30 beds or less).) Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the site's Operating Certificate Number as the Program/Site Identification Number.

Units of Service: One hour of service equals one unit of service.

0100 – OMRDD Clinic Treatment Facility (Free-Standing Clinic)

A certified physical space or setting and/or its services, including any certified satellite location(s) providing clinical services pursuant to Part 679, principally to persons with developmental disabilities, where such services are provided on an outpatient (i.e., non-residential) basis. The term "facility" also includes the headquarters for administration, management (including clinical records management), and clinician office (but not treatment) space for a provider authorized to provide exclusively off-site services, which holds an appropriate certificate of occupancy in accordance with the requirements of locality having jurisdiction.

Note: Off-site Services are services delivered at any location(s) other than the clinic's **main site** or a certified **satellite site**.

For this program type, reporting is required based on operating certificate number, which should be used as the Program/Site Identification Number. All costs and services associated with an operating certificate number, including satellite(s) and off-site services, should be included in one column.

Units of Service: Units of Service as defined (Part 679.5) is an allowable clinic service delivered at the main certified site, or at a certified satellite site or as an Off-site service. There is only one (1) billable visit per day per person regardless of the number of services provided during a given visit.

0101 – OMRDD Clinic Treatment Facility (Clinic Joint Venture)

A Clinic Joint Venture is defined as a Voluntary operated Clinic Treatment Facility certified as a State clinic satellite on the local DDSO state-operated clinic operating certificate. There is a formal contractual arrangement between a DDSO and a Voluntary Provider to operate a Clinic Treatment Facility as a Clinic Satellite of the DDSO.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the Program Code.

All costs and services associated with this satellite and any other additional certified satellites under this affiliation should be included in this cost center. Reimbursement received should be reported as Net Deficit Funding.

Units of Service: Units of Service as defined (Part 679.5) is an allowable clinic service delivered at the main certified site, or at a certified satellite site or as an Off-site service. There is only one (1) billable visit per day per person regardless of the number of services provided during a given visit.

0120 - Specialty Clinic

Intensive diagnosis and/or medically prescribed treatment services provided during day and/or evening hours to mentally retarded and developmentally disabled persons who are served as needed for short periods of actual service involvement. Such programs are affiliated with a hospital or facility which holds, in addition to OMRDD certification, certification in accordance with Article 28 of the Public Health Law. The rates for payment and duration of visit are cost-related and determined in accordance with procedures established by the Office of Health Systems Management for the specific facility and the particular service being offered.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent.

The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: Count each billable visit as one unit of service.

0150 - Family Support Services

Those services other than basic residential and habilitative services needed by people with developmental disabilities to sustain themselves in appropriate community settings. They also include those services that families with disabled members need to provide environmental supports and maintenance of family stability and integrity. Family Support Services typically include information and referral, parent training, family counseling, recreation, home-based care, adaptive equipment and home modification, and legal services.

List free standing respite programs separately under 0650.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: As per contract.

For Budget Format: As per contract.

0190 - Program Development Grants

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. Include the name and address of the site that is being developed. Include the operating certificate, if known, as the Program/Site Identification Number. It the operating certificate number is not known, create a Program/Site Identification Number by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: Not applicable.

0200 - Day Treatment Free Standing

A planned combination of diagnostic, treatment, and rehabilitative services provided to mentally retarded and developmentally disabled individuals in need of a broader range of services than those provided in clinic treatment programs. Persons provided day treatment will attend regularly for periods in excess of three hours. Day Treatment Programs may vary widely in the services offered, the level of disability of participants, the staffing plan, the program goals and the types and numbers of cooperative agency relationships.

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the site's Operating Certificate Number as the Program/Site Identification Number.

Revenue for transportation to and from Day Treatment should be reported as "Transportation, Medicaid" (CFR-1, Line 76) for Medicaid eligible consumers and/or "Transportation, Other" (CFR- 1, Line 77) for non-Medicaid eligible consumers.

See Program Codes 0670 and 0880 for specifics on reporting expenses regarding transportation to and from Day Treatment.

Note: Do not include Day Treatment/HCBS Day Habilitation To/From Transportation expense in this program. If a vehicle or staff person is assigned to this program, but is used for to/from transportation, the related expenses must be reported under Program

Code 0670. See Program Code 0670 for instructions on reporting and allocating these expenses.

Units of Service:
Half-day visit: 3 but less than 5 hours.

Full-day visit: 5 hours or more.

0202 - Day Treatment Partial

Same as 0200 preceding, except available only in co-located setting with an emphasis on some subcontract work being performed.

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the site's Operating Certificate Number as the Program/Site Identification Number.

Units of Service: One unit = 1.5 hours but less than 3 hours

0214 - HCBS Supported Employment

Supported Employment services assist people in finding and keeping employment that the person finds meaningful. It provides appropriate staff and/or supports to help individuals obtain and maintain paid employment. The service takes place in integrated work settings in the community, which provide opportunities for regular interactions with individuals who do not have disabilities and who are not paid to provide services to people with a developmental disability.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Units of Service: One month of service equals one unit of service.

0215 - HCBS Environmental Modifications

Selected internal and external changes to the person's physical home environment, required by the person's individualized service plan, which are necessary to ensure the health, welfare and safety of the person of which enable him or her to function with greater independence in the home and without which the person would require institutionalization. Environmental modifications will be provided on a limited one-time only basis to the extent necessary to enable people with physical infirmities and disabilities to live safely in community homes outside the institutional setting. Report all similar services as one program/site. The revenue is reported as Medicaid.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

100% of Environmental Modification cost is to be reported as Equipment or Property-Other as appropriate. If property or equipment belongs to the service provider, the cost will be depreciated on the service provider's books and will be a reconciling item since 100% of the cost is reported in the first year.

Units of Service: Not applicable.

0216 - HCBS Adaptive Technologies

The provision of devices, aids, controls, appliances or supplies of either a communication or adaptive type determined necessary to enable the person to increase his or her ability to function in a home and community based setting with independence and safety. The aid, whether of a communication or adaptive type, must be documented in the person's individualized service plan as being essential to the person's habilitation, ability to function or safety, and essential to avoid or delay more costly institutional placement. Report all similar services as one program/site. The revenue is reported as Medicaid.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Units of Service: Not applicable.

0219 - HCBS Residential Habilitation Service (At Home)

Residential habilitation services are provided in the person's place of residence. This includes assistance with acquisition, retention or improvements of self-help skills related to activities of daily living, such as personal grooming and cleanliness, bed-making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Do not include any expenses for programming provided as day habilitation.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Units of Service: Contact during one 24-hour period, regardless of duration, equals one unit of service.

0220 - HCBS Residential Habilitation Services (Family Care)

Residential habilitation services are provided in the person's place of residence. This includes assistance with acquisition, retention or improvements of self-help skills related to activities of daily living, such as personal grooming and cleanliness, bed-making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Do not include any expenses for programming provided as day habilitation. The Difficulty of Care (DOC) payment should be reported as a Contracted Direct Care Personal Services expense.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Units of Service: One participant day equals one unit of service.

0221 - HCBS Assistive Supports

Assistive supports includes support staff for an individual or family with assistance and/or training in order to enhance the independence of the individual. Assistive supports must be included in the individual's service plan. Report all similar services as one program/site.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Units of Service: Not applicable.

0222 - Other Service Coordination (Non-Medicaid)

A service which assists persons with developmental disabilities and mental retardation in gaining access to necessary services and supports appropriate to the needs of the individual. Other Service Coordination is provided by qualified service coordinators and uses a person centered planning process in developing, implementing, and maintaining an Individualized Service Plan (ISP) with and for a person with developmental disabilities or mental retardation. Other Service Coordination promotes the concepts of choice, individualized services and supports, and consumer satisfaction and is designed for individuals who are non-Medicaid eligible. The revenue is reported as “Other, Mirrored Services.”

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Units of Service: One month of service equals one unit of service.

0223 - HCBS Group Day Habilitation Service

HCBS day habilitation provides assistance with acquisition, retention or improvement of self-help, socialization and adaptive skills. Group Day Habilitation services are typically provided to two or more enrolled consumers on weekdays and have a service start time prior to 3:00 p. m.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Revenue for transportation to and from HCBS Group Day Habilitation should be reported as "Transportation, Medicaid" (CFR-1, line 76) for Medicaid eligible consumers and/or "Transportation, Other" (CFR-1, line 77) for non-Medicaid eligible consumers. See Program Codes 0670 and 0880 for specifics on reporting expenses regarding transportation to and from HCBS Day Habilitation.

Note: Do not include Day Treatment/HCBS Day Habilitation To/From Transportation expense in this program. If a vehicle or staff person is assigned to this program, but is used for to/from transportation, the related expenses must be reported under Program Code 0670. See Program Code 0670 for instructions on reporting and allocating these expenses.

Units of Service:
Half Unit: 2 or more hours with at least one face-to-face service

Full Unit: 4 to 6 hours with at least two face-to-face services

0224 - HCBS Supplemental Group Day Habilitation Service

HCBS day habilitation provides assistance with acquisition, retention or improvement of self-help, socialization and adaptive skills. Supplemental Group Day Habilitation services are typically provided to two or more enrolled consumers on weekdays with a service start time at 3:00 p. m. or later or anytime on weekends.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Revenue for transportation to and from HCBS Group Day Habilitation should be reported as "Transportation, Medicaid" (CFR-1, line 76) for Medicaid eligible consumers and/or "Transportation, Other" (CFR-1, line 77) for non-Medicaid eligible consumers.

See Program Codes 0670 and 0880 for specifics on reporting expenses regarding transportation to and from HCBS Day Habilitation.

Note: Do not include Day Treatment/HCBS Day Habilitation To/From Transportation expense in this program. If a vehicle or staff person is assigned to this program, but is used for to/from transportation, the related expenses must be reported under Program Code 0670. See Program Code 0670 for instructions on reporting and allocating these expenses.

Units of Service:
Half Unit: 2 or more hours with at least one face-to-face service

Full Unit: 4 to 6 hours with at least two face-to-face services

0225 - HCBS Individual Day Habilitation Service

HCBS day habilitation provides assistance with acquisition, retention or improvement of self-help, socialization and adaptive skills. Individual Day Habilitation services are provided with a staff-to consumer ratio of no greater than one consumer per staff member and are delivered on weekdays and have a service start time prior to 3:00 p. m.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Revenue for transportation to and from HCBS Group Day Habilitation should be reported as “Transportation, Medicaid” (CFR-1, line 76) for Medicaid eligible consumers and/or “Transportation, Other” (CFR-1, line 77) for non-Medicaid eligible consumers.

See Program Codes 0670 and 0880 for specifics on reporting expenses regarding transportation to and from HCBS Day Habilitation.

Note: Do not include Day Treatment/HCBS Day Habilitation To/From Transportation expense in this program. If a vehicle or staff person is assigned to this program, but is used for to/from transportation, the related expenses must be reported under Program Code 0670. See Program Code 0670 for instructions on reporting and allocating these expenses.

Units of Service: Report using billable units. (i.e.: one quarter hour equals one unit of service.)

0226 - HCBS Supplemental Individual Day Habilitation Service

HCBS day habilitation provides assistance with acquisition, retention or improvement of self-help, socialization and adaptive skills. Supplemental Individual Day Habilitation services are provided with a staff-to-consumer ratio of no greater than one consumer per staff member

and are delivered on weekdays with a service start time at 3:00 p. m. or later or anytime on weekends.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Revenue for transportation to and from HCBS Group Day Habilitation should be reported as "Transportation, Medicaid" (CFR-1, line 76) for Medicaid eligible consumers and/or "Transportation, Other" (CFR-1, line 77) for non-Medicaid eligible consumers.

See Program Codes 0670 and 0880 for specifics on reporting expenses regarding transportation to and from HCBS Day Habilitation.

Note: Do not include Day Treatment/HCBS Day Habilitation To/From Transportation expense in this program. If a vehicle or staff person is assigned to this program, but is used for to/from transportation, the related expenses must be reported under Program Code 0670. See Program Code 0670 for instructions on reporting and allocating these expenses.

Units of Service: Report using billable units. (i.e.: one quarter hour equals one unit of service.)

0227 - HCBS Prevocational Services (Services on or after 1/1/06)

Services that are aimed at preparing an individual for paid or unpaid employment, but which are not job task oriented. Services include teaching such concepts as compliance, attending, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate satisfactory in a transitional sheltered workshop within one year (excluding supported employment programs). Report all similar services as one program/site.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code

Units of Service:
Half Unit: 2 or more hours with at least one face-to-face service

Full Unit: 4 or more hours with at least two face-to-face services

0229 - Medicaid Service Coordination (MSC)

A service which assists persons with developmental disabilities and mental retardation in gaining access to necessary services and supports appropriate to the needs of the

individual. MSC is provided by qualified service coordinators and uses a person centered planning process in developing, implementing, and maintaining an Individualized Service Plan (ISP) with and for a person with developmental disabilities or mental retardation. MSC promotes the concepts of choice, individualized services and supports, and consumer satisfaction. The revenue is reported as Medicaid.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Units of Service: One month of service equals one unit of service.

0231 - HCBS Supervised IRA (Room and Board and Residential Habilitation Services)

A Supervised IRA has staff onsite or proximately available at all times when the individuals are present.

Report expenses for both Room and Board and Residential Habilitation Services. This includes assistance with acquisition, retention or improvements of self-help skills related to activities of daily living, such as personal grooming and cleanliness, bed-making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting.

Residential habilitation services are provided in the person's place of residence. Do not include any expenses for programming provided as day habilitation. Do not include expenses for Residential Habilitation Services or Room and Board for HCBS Supportive IRAs or Part 671 Community Residences (Supervised or Supportive).

Program type reporting is required for this program. All program site expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the Agency Code and the last three digits of the Program Code.

Note: Do not include Day Treatment/HCBS Day Habilitation To/From Transportation expense in this program. If a vehicle is assigned to this program, but is used for to/from transportation, the related expenses must be reported under Program Code 0670. See Program Code 0670 for instructions on reporting and allocating these expenses.

Units of Service: One month of service equals one unit of service.

0232 - HCBS Supportive IRA (Room and Board and Residential Habilitation Services)

A Supportive IRA provides practice in independent living under variable amounts of oversight delivered in accordance with the individual's needs for supervision. Staff typically are not onsite nor proximately available at all times when the individuals are present.

Report expenses for both Room and Board and Residential Habilitation Services. This includes assistance with acquisition, retention or improvements of self-help skills related to activities of daily living, such as personal grooming and cleanliness, bed-making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting.

Residential habilitation services are provided in the person's place of residence. Do not include any expenses for programming provided as day habilitation. Do not include expenses for Residential Habilitation Services or Room and Board for HCBS Supervised IRAs or Part 671 Community Residences (Supervised or Supportive).

Program type reporting is required for this program. All program site expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the Agency Code and the last three digits of the Program Code.

Note: Do not include Day Treatment/HCBS Day Habilitation To/From Transportation expense in this program. If a vehicle is assigned to this program, but is used for to/from transportation, the related expenses must be reported under Program Code 0670. See Program Code 0670 for instructions on reporting and allocating these expenses.

Units of Service: One month of service equals one unit of service.

0233 - HCBS Freestanding Respite

Provision of temporary, short-term relief for families and care providers which enables them to arrange for their vacations, emergency coverage in the event of family or provider illness or death, or for a break from constant, intensive participant care and supervision. This applies only to respite provided in a freestanding center authorized or certified by OMRDD.

Site specific reporting is required for this program type. Each site is reported separately in its own column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this Program Code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: Report using billable units. (i.e.: one quarter hour equals one unit of service.)

0234 - Options for People Through Services (NYS OPTS)

Report all expenses and revenues related to an approved contract established under the NYS OPTS program. The revenue should be reported on Line 75 of CFR-1 ("OMRDD Residential Room and Board/NYS OPTS") and the expenses are reported using all applicable expense line items.

Service Type reporting is required for this program. For each Service Type included in the contract there must be a separate column on the CFR. Use the contract number as the Program/Site Identification Number (use "0" to replace the starting letter of the contract in order to create a seven digit number). Use the two digit Service Type indicator as the index code.

OPTS Service Types: 01 Supervised IRA with Res Hab; 02 Supportive IRA with Res Hab; 03 Comp Res Hab/Supervised IRA; 04 Comp Res Hab/Supportive IRA; 05 Group Day Habilitation; 06 Individual Day Habilitation; 07 Pre-Vocational; 08 Blended DP; 09 At-Home Res Hab; 10 Hourly Respite; 11 Free Standing Respite; 12 Monthly Supported Employment (SEMP); 13 Family Care; 18 Supplemental Group Day Habilitation; 19 Blended DPS; 20 Blended PS; 22 General DD-Hourly; 23 General DD-Per Diem; 24 General DD-Monthly; 25 Supplemental Individual Day Habilitation; 26 General DD-Per Unit; 27 Blended DS; 99 Other.

Note: For NYS OPTS approved contracts for the Day Habilitation Service Type: revenue for transportation to and from Day Habilitation should be reported as "Transportation, Medicaid" (CFR-1, Line 76) for Medicaid eligible consumers and/or "Transportation, Other" (CFR-1, Line 77) for non-Medicaid eligible consumers.
Do not include Day Habilitation To/From Transportation expense in this program. If a vehicle or staff person is assigned to this program, but is used for to/from transportation, the related expenses must be reported under Program Code 0670. See Program Codes 0670 and 0880 for specifics on reporting expenses regarding transportation to and from Day Habilitation.

Units of Service: Report units as per Service Type.

0235 - HCBS Other Than Freestanding Respite

Provision of temporary, short-term relief for families and care providers which enables them to arrange for their vacations, emergency coverage in the event of family or provider illness or death, or for a break from constant, intensive participant care and supervision. This applies only to respite provided in other than a freestanding respite center.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Units of Service: Report using billable units. (i.e.: one quarter hour equals one unit of service.)

0330 - Day Training

A program or planned combination of services provided to developmentally disabled persons whose level of disability is not so severe as to require day treatment services but

whose functional behavior deficits limit their ability to function independently. The goal of day training programs is to provide program interventions that will assist developmentally disabled persons in the acquisitions of knowledge and skills that will enable them to improve their personal, social, and vocational skills and their ability to function independently. Day training also includes programs consisting of specialized developmental services that are operated with the goal of providing developmentally disabled persons with habilitation and social skills which will enable the individual to maintain gains made in other programs or to gain entry to a level of programming requiring more independent functioning. The program may operate as a complement to other day programs or on an intermittent basis to accommodate gaps in regular programs. Included here could be afternoon, evening or weekend programs operated by service providers who operate other day services. The emphasis of these programs is on the maintenance of existing skills and the development of social, recreational, and leisure activities which are intellectually and interpersonally stimulating and augment health maintenance. This may include recreational, music movement and art activities as indicated in the participant's program plan.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service:
Less than half-day visit: Less than 3 hours = .30

Half-day visit: 3 but less than 5 hours = .50

Full-day visit: 5 hours or more = 1.00

For Budget Format: Count each visit as one visit.

0340 - Certified Work Activity/Sheltered Workshop

A program certified by the U.S. Department of Labor and OMRDD which provides services and experiences to participants with the goal of increasing their economic independence. Work activity programs would tend to emphasize prevocational skills with the objectives of task orientation, coordination skills, and the like with the goal of preparing the individual to function in a sheltered workshop program. Sheltered workshops are for developmentally disabled persons who have the prevocational skills necessary to perform occupational tasks with an acceptable level of output. The goals of such programs are to train individuals in the occupational tasks to be accomplished, provide necessary and appropriate adjustment training and to provide training and experience that will assist the individual in improving his/her performance. An example of this would be a sheltered employment program with the goal of assisting the handicapped person to progress toward competitive employment. The program objective is competitive employment if the potential exists, or long-term

employment within a sheltered workshop if competitive employment is not feasible. Program elements would include:

(a) Diagnostic evaluation and testing;

(b) Controlled and supervised working experience for training, work adjustments, or employment in conjunction with other services, such as counseling and group therapy; and

(c) Assessment of progress, referral, and follow-up.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service:
Less than half-day visit: Less than 3 hours = .30

Half day visit: 3 but less than 5 hours = .50

Full-day visit: 5 hours or more = 1.00

0360 - Classroom Education

A program of special education services provided on a consolidated basis with diagnosis and/or rehabilitative services for mentally retarded and developmentally disabled persons between the ages of 5 and 21. Examples of typical services include classroom education for school-aged children; diagnosis and evaluation; instruction in pre-academic skill areas; physical, recreational, and speech and hearing therapy; and counseling of families or other collaterals of participants.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: Each visit.

For Budget Format: Count each visit as one visit.

0370 - Preschool Program

Program which provides services to developmentally disabled individuals under the age of five. The goal of such services is to provide preventive and ameliorative services to children at risk of developmental disability diagnosis in order to prepare them for acceptance into a school program operated by the public schools. The activities of such programs would include but are not limited to pre-academic skills, social interaction skills, self care skills and infant stimulation.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: Each visit.

0380 - Transitional Employment

Short term intervention to lead to employment at or above minimum wage. Aimed at individuals who need assistance in learning marketable skills, good work habits and appropriate on-the-job socializing and who can become competitively employed within a time limited period. This takes place in integrated community work settings and emphasizes support provided at the worksite.

Contract Budget consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the Agency Code and the last three digits of the Program Code. Where more than one column will be created for this Program Code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: One hour of service provided to or on behalf of each participant equals one unit of service.

For Budget Format: Count the number of direct hours of service provided to individual participants.

0390 - Supported Employment (Non-HCBS Waiver)

Supported employment is designed for individuals who, because of the severe nature of their disabilities, require ongoing interventions and supports in order to obtain and maintain employment. It is not for those who would be better served in time limited preparations for competitive employment. The individuals must be engaged in meaningful work for wages on a full-time or part-time schedule. The employment must be in an integrated work setting providing frequent daily social interactions with people who are not disabled and who are not paid care givers. Federal guidelines suggest limiting the number of supported employees to

eight per site. Supported employment exists only when there is on-going publicly financed support directly related to the maintenance of the supported employment.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: For Supported Employment programs that are funded via direct contract, report the direct care units of service. One hour of service provided to or on behalf of each consumer equals one unit of service. Direct care hours/units shall include: hours of pre-employment, hours of on-site intervention, and hours of off-site intervention, as reported on lines 17, 18 and 19 of the Individual's Quarterly Report. For further clarifications, regarding these categories, refer to the "New York State Interagency Supported Employment Program Instructions for the Individual's Quarterly Progress".

For Budget Format: Count the number of direct hours of service provided to individual participants.

0410 - Individualized Support Services

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: As per contract.

0411 - HCBS Consolidated Supports and Services

Only agencies that are designated as a Fiscal Employer/Agent should report under this Program Code.

Program type reporting is required for this program. All expenses paid and revenues claimed by the Fiscal Employer/Agent are to be aggregated and reported in one column. Expenses are reported using all applicable expense line items. Revenue is reported as Medicaid for Medicaid eligible individuals or as "Other Revenue" for non-Medicaid eligible individuals.

The Program/Site Identification Number is created using the first four digits of the agency code and the last three digits of the program code.

Units of Service: One unit of service equals one month.

0413 - HCBS Family Education and Training

HCBS Family Education and Training is training given to the families of consumers enrolled in the Home and Community Based waiver who are under 18 years of age. The purpose of family education and training is to enhance the decision making capacity of the family unit, provide orientation regarding the nature and impact of developmental disability upon the consumer and his or her family and teach them about service alternatives. Family education and training is distinct from service coordination in that the purpose is to support the family unit in understanding the coping with the developmental disability. The information and knowledge imparted in family education and training increases the chances of creating a support environment at a home and decreases the chances of a premature residential placement outside the home.

Family education and training is given in a two hour segment twice a year. Sessions may be private or in groups of families. Any personnel knowledgeable in the topics covered may conduct the sessions. Most frequently, this will be service coordinators, but it may also include other clinicians and experts in such fields as the law and finances pertaining to disabilities.

Program type reporting is required for this program. All expenses and revenues for all program sites are to be aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

If the individual receiving the services is HCBS waiver eligible, the funding source is Medicaid. If the individual is not HCBS waiver eligible, the funding is 100% OMRDD funded.

Units of Service: One unit of service equals a minimum of two hours. No more than 2 units of service per eligible person shall be provided on an annual basis to each family.

0414 - Epilepsy Services

Services needed by developmentally disabled individuals with epilepsy to sustain themselves in appropriate community settings. Epilepsy Services typically include, but are not limited to, information and referral, counseling, case management, education and support groups.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: As per contract.

0415 - HCBS Live-In Caregiver

When a live-in personal caregiver who is unrelated to the individual receiving care provides approved services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the home or residence of the individual served may be reimbursed.

If the individual receiving the services is HCBS waiver eligible, the funding source is Medicaid. If the individual is not HCBS waiver eligible, the funding is 100% OMRDD funded.

Program type reporting is required for this program. All expenses and revenues for all program sites are to be aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Units of Service: One unit of service equals one month.

0416 - HCBS Waiver Plan of Care Support Services

HCBS Waiver Plan of Care Support Services are services needed to review and maintain a current Individualized Service Plan (ISP) for the consumer, and to maintain documentation of the consumer's level of care eligibility.

If the individual receiving the services is HCBS waiver eligible, the funding source is Medicaid. If the individual is not HCBS waiver eligible, the funding is 100% OMRDD funded.

Program type reporting is required for this program. All expenses and revenues for all program sites are to be aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Units of Service: One unit of service equals six months.

0610 - Recreation

A program of social, recreational, and leisure activities which are intellectually and interpersonally stimulating but which are not necessarily part of a goal-based program plan. Agencies which provide no other types of programs should report this service in the recreation category. Recreation activities which are part of other programs should not be reported as part of recreation programs.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: Each visit.

For Budget Format: Count each visit as one visit.

0630 - Homemaker Services

Services provided in the client's home by a trained person, who is not a member of the household. Services include, but are not limited to, assisting and training the client in home management skills, household tasks, and hygiene skills; and, the training and/or assistance to parents/collaterals in the provision of such services to the developmentally disabled family member.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: Each staff hour.

For Budget Format: Count the total number of homemaker services staff hours.

0670 - Consumer Transportation

The provision of transportation for persons, as specified in the individual service plan, including all necessary supportive services for full and effective integration of the person into community life. The vehicles utilized can be either centrally located, not assigned to a particular program or used exclusively for To/From Day Habilitation.

Service providers who operate their own transportation cost center should report under this program code, as follows:

Revenue: Revenues reported under program code 0670 are to be aggregated and reported in one column.

The only revenues that should be reported under program code 0670 are those revenues received by the reporting agency from billing another agency for the transportation of the other agency's consumers. Transportation revenue included in a rate, fee or price should not be reported under program code 0670. Transportation revenue included in a rate, fee or price should be reported in the appropriate program/site.

Expense: Expenses reported under program code 0670 are to be aggregated and reported in one column on the appropriate expense lines (Depreciation – Equipment, Interest – Vehicle, etc.) of Schedule CFR-1.

The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

For each program/site operated by your agency for which other than to and from Day Treatment or HCBS Day Habilitation transportation expenses are included in 0670, please report the appropriate allocation of those expenses to that program/site on line 68a of CFR-1. The basis for this allocation must be reasonable and documented. Such allocation methods may include the number of trips or the number of individuals.

For each program/site operated by your agency for which transportation to and from Day Treatment or HCBS Day Habilitation expenses are included in 0670, please report the appropriate allocation of those expenses to that program/site on line 68b of CFR-1. The basis for this allocation must be reasonable and documented. Such allocation methods may include the number of trips or the number of individuals.

Units of Service: One unit of service equals one round trip per person. Note: For one way trips, count two one way trips as one unit of service.

0750 - Information and Referral

The initial process of contacting, interviewing and evaluating persons for the expressed purpose of preliminary determination of the appropriateness of such persons for the receipt of particular services and/or programs including the need for further assessment. Such activities also include the requested imparting of factual knowledge about the availability of particular services, answers to administrative questions, or statements and interpretation of specified clinical data. Included in this category also is the completion and forwarding of written materials that will allow the individual to access or will facilitate access to the appropriate program or service.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: Each staff hour.

For Budget Format: Count the total number of information and referral service staff hours.

0780 - NYC Housing Resource Consortium

A program that provides guidance to consumers, families of advocates, agencies and BDSO's on the development and implementation of small, individualized living environments in New York City.

0810 - Case Management (Non-Medicaid)

Case management - Activities aimed at linking the patient to the service system and at coordinating the various services in order to achieve a successful outcome. The objective of case management in a mental health system is continuity of care and service. Services may include linking, monitoring and case-specific advocacy.

Linking - The process of referring or transferring a patient to all required internal and external services that include the identification and acquisition of appropriate service resources.

Monitoring - Observation to assure the continuity of service in accordance with the patient's treatment plan.

Case-Specific Advocacy - Interceding on behalf of a patient to assure to services required in the individual service plan. Case management activities are expediting and coordinative in nature rather than the primary treatment services ordinarily provided by the therapist.

Case management services are provided to enrolled patients for whom staff are assigned a continuing case management responsibility. Thus, routine referrals would not be included unless the staff member making the referral retains a continuing active responsibility for the patient throughout the system of service.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service:
Direct staff hours - The number of staff hours spent by staff in providing case management services face-to-face or by telephone directly to patients or collaterals.

Indirect staff hours - The number of staff hours spent by staff in providing case management services on behalf of patients other than face-to-face or by telephone directly with patients or collaterals.

For Budget Format: Count the total number of staff hours (combine direct and indirect).

0880 - Subcontract Services

This program code is used to report all expenses associated with sub-contract provider agencies for program delivery, and for all revenues received by the reporting agency on behalf of subcontracted provider agencies.

The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be

created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Transportation Subcontracts:
For service providers that subcontract for any transportation other than to and from Day Treatment or HCBS Day Habilitation, please report the appropriate allocation of those expenses to that program/site on line 68a of CFR-1. The basis for this allocation must be reasonable and documented. Such allocation methods may include the number of trips or the number of individuals.

For service providers that subcontract for transportation to and from Day Treatment or HCBS Day Habilitation, please report the appropriate allocation of those expenses to that program/site on line 68b of CFR-1. The basis for this allocation must be reasonable and documented. Such allocation methods may include the number of trips or the number of individuals.

Transportation revenue included in a rate, fee or price should not be reported under Program Code 0880. Transportation revenue included in a rate, fee, or price should be reported in the appropriate program/site.

Units of Service:

For transportation, one unit of service equals one round trip per person. Note: For one way trips, count two one way trips as one unit of service.

0890 - Local Governmental Unit (LGU) Administration

The Local Governmental Unit is defined in Article 41 of the Mental Hygiene Law. This program category includes all local government costs related to administering mental hygiene services that are provided by a local government or by a voluntary agency pursuant to a contract with a local governmental unit. LGU Administration is funded cooperatively by OASAS, OMH and/or OMRDD. As such, this program is reported as a shared program on the core schedules (CFR-1 through CFR-6) of the CFR. LGU Administration expenses and revenues related to each State Agency are reported on State Agency specific claiming schedules (DMH-2 and DMH-3). **Note**: This program type is exempt from the Ratio Value allocation of agency administration.

Units of Service: Not applicable.

1053 - Community Residence Part 671 Supportive - Residential Habilitation

Report one aggregated column for all similar services.

Expenses for the following may be included:

Personal Services
Vacation Leave

Mandated Fringe
Non-mandated Fringe
Transportation Related
Staff Travel
Contracted Direct Care and Clinical Care
Other OTPS
Provider Paid Equipment

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the Agency Code and the last three digits of the Program Code. If Program Code 1053 is reported, there must also be one column of Program Code 1054 reported.

Note: Do not include Day Treatment/HCBS Day Habilitation To/From Transportation expense in this program. If a vehicle or staff person is assigned to this program, but is used for to/from transportation, the related expenses must be reported under Program Code 0670. See Program Code 0670 for instructions on reporting and allocating these expenses.

Units of Service: For each unit of service, count one participant day.

1054 - Community Residence Part 671 Supportive - Room and Board

Room and Board. Report one aggregated column for all supportive sites.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. If Program Code 1054 is reported, there must also be one column of Program Code 1053 is reported.

Report only those costs normally occurring in a room and board situation. Additional costs because program participants may have special needs are Res. Hab. costs.

Note: Do not include Day Treatment/HCBS Day Habilitation To/From Transportation expense in this program. If a vehicle or staff person is assigned to this program, but is used for to/from transportation, the related expenses must be reported under Program Code 0670. See Program Code 0670 for instructions on reporting and allocating these expenses.

Units of Service: For each unit of service, count one participant day.

1090 - Intermediate Care Facility for the Developmentally Disabled (Over 30 Beds)

A facility operated by or subject to certification by the Office of Mental Retardation and Developmental Disabilities with a capacity of over 30 in accordance with the requirements of

Part 681 of Title 14 NYCRR and 42 CFR 442. Such facilities provide active programming, room and board, and continuous 24-hour per day supervision. They are located within the population areas of non-developmentally disabled persons. They are not of the facility type known as developmental center or school as defined by Section 13.17 of the Mental Hygiene Law.

If this Program Code is reported, a corresponding OMRDD-1, ICF/DD Schedule of Service, must be completed.

Note: When the ICF/DD rate includes an add-on component for an ICF/DD School contract, report all expense and revenue in a discreet column as program code 3090 or 3091 as appropriate. Add-on for ICF/DD Sheltered Workshop - use program code 2090 or 2091 as appropriate. Add-on for ICF/DD Day Training - use program 5090 or 5091 as appropriate. When the ICF/DD rate includes funding for day program services, report all expense in a discreet column as Program Code 6090, Day Program Services Included in the ICF/DD Reimbursement Rate (On-Site) or Program Code 6091, Day Program Services Included in the ICF/DD Reimbursement Rate (Off-Site). Add-on for VOICF/DD, Day Services Contract – use program code 7090 or 7091 as appropriate.

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the site's Operating Certificate Number as the Program/Site Identification Number.

Note: Do not include Day Treatment/HCBS Day Habilitation To/From Transportation expense in this program. If a vehicle or staff person is assigned to this program, but is used for to/from transportation, the related expenses must be reported under Program Code 0670. See Program Code 0670 for instructions on reporting and allocating these expenses.

Units of Service: For each unit of service, count one participant day.

For Budget Format: Count each participant day as one day.

1091 - Temporary Use Beds (TUBS) in an Intermediate Care Facility (Over 30 Beds)

When a bed (certified or uncertified) in an ICF/DD (over 30 beds) is used as a temporary use bed, the associated revenues and expenses should be reported under this program code. (Do not report the same revenue and expense under program code 1090 – Intermediate Care Facility (over 30 beds).)

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the site's Operating Certificate Number as the Program/Site Identification Number.

Units of Service: One hour of service equals one unit of service.

1150 - Traumatic Brain Injury (TBI)

Those services which provide individuals with TBI and their families with information, referral, counseling, advocacy, training and emotional support. A professional approach includes intake, follow up documentation and confidentiality. In addition, outreach to schools, hospitals and other human service agencies, as well as, linkage to other professionals through client specific discussion is provided.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Units of Service: As per contract.

For Budget Format: As per contract.

1190 - Special Legislative Grants

Specific grants funded as a result of legislative member support, targeted for a particular purpose.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the Agency Code and the last three digits of the Program Code. Where more than one column will be created for this Program Code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: Not applicable.

1220 - Care at Home - III

A Medicaid Waiver service providing financial assistance to families with children living at home who have severe disabilities or medical conditions. Parental income and resources are not considered when determining the child's eligibility for Medicaid. Medicaid services include Service Coordination, Respite Care and Assistive Technologies. For care at Home III only: the family must have applied for out-of-home residential placement for the child.

Program type reporting is required for this program. All expenses and revenues for all program sites are to be aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code

Units of Service: Not applicable.

1850 - Voluntary Preservation Project-Formerly Known as Voluntary Operated Maintenance Contract (Also Known as VAAM)

Program type reporting is required for this program. All Program/Site expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the Agency Code and the last three digits of the Program Code. Costs related to Voluntary Preservation Projects may not be included with any other program or site-specific reporting. 100% of Voluntary Preservation Project cost is to be reported as Equipment or Property, as appropriate. If the cost is depreciated on the service provider's books, it will be a reconciling item since 100% of the cost is reported in the first year.

Units of Service: As per contract.

2090 - Voluntary Operated Intermediate Care Facility for the Developmentally Disabled, Sheltered Workshop

Sheltered Workshop services defined as part of the VOICF/DD Active Treatment Plan that are provided to VOICF/DD consumers.

When the service provider operates both the VOICF/DD and the Sheltered Workshop program, the increased portion of the rate and the associated expense are to be reported in this discreet column using the operating certificate number of the VOICF/DD as the program/site identification number. The revenue is reported as Medicaid and the expense is reported using all applicable expense line items. Do not include this revenue and expense in the column used to report the workshop program.

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the ICF/DD's Operating Certificate Number as the Program/Site Identification Number. For each Program Code 2090 column that is reported, there must be a corresponding Program Code 0090 or 1090 column reported

Units of Service: One day equals one unit of service.

2091 - Voluntary Operated Intermediate Care Facility for the Developmentally Disabled, Sheltered Workshop (Not Operated by Service Provider)

When VOICF/DD consumers attend a Sheltered Workshop program that is not operated by the service provider, the increased portion of the rate and the associated expenses are to be reported in a discreet column under program code 2091 (VOICF/DD, Sheltered Workshop) using the operating certificate number of the ICF/DD as the program/site identification number. Report revenue as "Medicaid" and expense as "OTPS-Other".

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the ICF/DD's Operating Certificate Number as the Program/Site Identification Number. For each Program Code 2091 column that is reported, there must be a corresponding Program Code 0090 or 1090 column reported.

Units of Service: One day equals one unit of service.

2190 - Developmental Disabilities Program Council Grants

Specific grants funded by the New York State Developmental Disabilities Program Council, targeted for a particular purpose.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent.

The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: Not applicable.

2220 - **Care at Home – IV & VI**

A Medicaid Waiver service providing financial assistance to families with children living at home who have severe disabilities or medical conditions. Parental income and resources are not considered when determining the child's eligibility for Medicaid. Medicaid services include Service Coordination, Respite Care and Assistive Technologies.

Program type reporting is required for this program. All expenses and revenues for all program sites are to be aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the Agency Code and the last three digits of the Program Code.

Units of Service: Not applicable.

3070 - Shelter Plus Care Housing

A federally-funded program of housing assistance specifically targeted to homeless persons with disabilities and their families. Funds may be used for the payment of rent stipends up to the federally established Fair Market rent, and associated administrative expenses. OMRDD requires any not-for-profit agency in receipt of these funds to report the funds in a separate program column. Shelter Plus Care Grants are made for five or ten years at a time. This program code is used in cases where the federal funds flow through OMRDD.

Units of Service: Not applicable.

For Budget Format: Not applicable.

3090 - Voluntary Operated Intermediate Care Facility for the Developmentally Disabled, School District Contract

If a service provider operates both the School and VOICF/DD programs, VOICF/DD add-on components to the VOICF/DD rate are to be reported as a stand alone program using program code 3090. The educational expenses and revenues relating to the approved private school program should be allocated based on the number of FTE students of the school program. The allocated expenses and revenues should be reported using program code 3090. The revenue is reported as Medicaid and the expense is reported using all applicable expense line items. The expenses and revenues of students served in the approved school program not residing in the ICF will continue to be reported to SED using program code 9000. Refer to program code 3091, if the School and VOICF/DD programs are not operated by the same service provider.

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the ICF/DD's Operating Certificate Number as the Program/Site Identification Number. For each Program Code 3090 column that is reported, there must be a corresponding Program Code 0090 or 1090 column reported.

Units of Service: One ICF residential day equals one unit of service.

3091 - Voluntary Operated Intermediate Care Facility for the Developmentally Disabled, School District Contracts (Not Operated by Service Provider)

Educational services defined as part of the VOICF/DD Active Treatment that are provided to ICF consumers via a contract between the VOICF/DD provider and a local school district. The increase to the VOICF/DD rate that was added for this service and the associated expense is to be reported in this discreet column. Use the operating certificate number of the consumers' ICF as the program/site identification number. The revenue is reported as Medicaid and the expense is reported as "OTPS - Other". When this condition exists in more than one VOICF/DD, multiple columns for the VOICF/DD School District Contract will be required.

For each VOICF/DD School District Contract column, there must be a corresponding Program Code 0090 or 1090 column reported.

Units of Service: For VOICF/DD School District Contract, one ICF residential day equals one unit of service.

4090 - State Operated Intermediate Care Facility for the Developmentally Disabled, Sheltered Workshop/Day Training

Sheltered Workshop/Day training services defined as part of the SOICF/DD Active Treatment Plan that are provided to SOICF/DD consumers via a contract. The revenue and the associated expense is to be reported in this discreet column using the operating certificate number of the day training program as the program/site identification number. The revenue is reported as Medicaid and the expense is reported using all applicable expense line items. Do not include this revenue and expense in the column used to report the day training program.

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the Operating Certificate Number of the day training program as the Program/Site Identification Number.

Units of Service: One day equals one unit of service.

5090 - Voluntary Operated Intermediate Care Facility for the Developmentally Disabled, Day Training

Day training services defined as part of the VOICF/DD Active Treatment Plan that are provided to VOICF/DD consumers.

When the service provider operates both the VOICF/DD and the Day Training program, the increased portion of the rate and the associated expense is to be reported in this discreet column using the operating certificate number of the VOICF/DD as the program/site identification number. The revenue is reported as Medicaid and the expense is reported using all applicable expense line items. Do not include this revenue and expense in the column used to report the day training program.

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the ICF/DD's Operating Certificate Number as the Program/Site Identification Number. For each Program Code 5090 column that is reported, there must be a corresponding Program Code 0090 or 1090 column reported.

Units of Service: One day equals one unit of service.

5091 - Voluntary Operated Intermediate Care Facility for the Developmentally Disabled, Day Training (Not Operated by Service Provider)

When VOICF/DD consumers attend a Day Training program that is not operated by the service provider, the increased portion of the rate and the associated expenses are to be reported in a discreet column under program code 5091 (VOICF/DD, Day Training) using the operating certificate number of the ICF as the program/site identification number. Report revenue as "Medicaid" and expense as "OTPS-Other".

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the ICF/DD's Operating Certificate Number as the Program/Site Identification Number. For each Program Code 5091 column that is reported, there must be a corresponding Program Code 0090 or 1090 column reported.

Units of Service: One day equals one unit of service.

6090 - Day Program Services Included in the ICF/DD Reimbursement Rate (On-Site)

Day program services for ICF/DD (Program Code 0090 and 1090) consumers whose comprehensive functional assessments require that such services be delivered by the ICF/DD and the funding for these services is included in the ICF/DD rate.

When an ICF/DD has reimbursement for Day Program Services provided by the ICF/DD included in its rate, the associated expenses of the day program are to be reported in a discreet column under Program Code 6090 using the operating certificate of the ICF/DD as the program/site identification number. The revenue is reported as Medicaid and the expense is reported using all applicable expense line items. Do not report Sheltered Workshop, School District Contract, or Day Training Expenses included in an ICF/DD rate under Program Code 6090. These should be reported using Program Codes 2090, 2091, 3090, 3091, 5090 or 5091.

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the ICF/DD's Operating Certificate Number as the Program/Site Identification Number. For each Program Code 6090 column that is reported, there must be a corresponding Program Code 0090 or 1090 column reported.

Units of Service:
Half-day service: 3 but less than 5 hours.

Full-day service: 5 hours or more.

6091 - Day Program Services Included in the ICF/DD Reimbursement Rate (Off-Site)

Day program services for ICF/DD (Program Code 0090 and 1090) consumers whose comprehensive functional assessments require that such services be delivered by other than the ICF/DD and the funding for these services is included in the ICF/DD rate.

When an ICF/DD has reimbursement for Day Program Services provided by other than the ICF/DD included in its rate, the associated expenses of the day program are to be reported in a discreet column under Program Code 6091 using the operating certificate of the ICF/DD as the program/site identification number. Do not report Sheltered Workshop, School District Contract, or Day Training Expenses included in an ICF/DD rate under Program Code 6091. These should be reported using Program Codes 2090, 2091, 3090, 3091, 5090 or 5091. If the service provider operates both the ICF/DD and the day program service, the expense is reported using all expense lines. If the service provider does not operate the day program service, the expense should be reported as "OTPS-Other". The revenue is reported as Medicaid.

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the ICF/DD's Operating Certificate Number as the Program/Site Identification Number. For each Program Code 6091 column that is reported, there must be a corresponding Program Code 0090 or 1090 column reported.

Units of Service:
Half-day service: 3 but less than 5 hours.

Full-day service: 5 hours or more.

7090 - Voluntary Operated Intermediate Care Facility for the Developmentally Disabled, Day Services Contract

This Program Code should be used when the ICF/DD rate includes an add-on for day programming services where the provider of day program service bills OMRDD directly.

When the service provider operates both the VOICF/DD and the Day Service program, the increased portion of the rate and the associated expense is to be reported in this discreet column using the operating certificate number of the VOICF/DD as the program/site identification number. The revenue is reported as Medicaid and the expense is reported using all applicable expense line items. Do not include this revenue and expense in the column used to report the day service program.

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the ICF/DD's Operating Certificate Number as the Program/Site Identification Number. For each Program Code 7090 column that is reported, there must be a corresponding Program Code 0090 or 1090 column reported.

Units of Service: Contact during one 24-hour period, regardless of the length of service, equals one unit of service.

7091 - Voluntary Operated Intermediate Care Facility for the Developmentally Disabled, Day Services (Not Operated by Service Provider)

This Program Code should be used when the ICF/DD rate includes an add-on for day programming services where the provider of day program service bills OMRDD directly.

When VOICF/DD consumers attend a Day Service program that is not operated by the service provider, the increased portion of the rate and the associated expenses are to be reported in this discreet column using the operating certificate number of the ICF as the program/site identification number. Report revenue as "Medicaid" and expense as "OTPS-Other".

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the ICF/DD's Operating Certificate Number as the Program/Site Identification Number. For each Program Code 7091 column that is reported, there must be a corresponding Program Code 0090 or 1090 column reported.

Units of Service: Contact during one 24-hour period, regardless of the length of service, equals one unit of service.

Not included in this manual.

Please see the Consolidated Reporting and Claiming Manual (CFR Manual)

Agency Administration Defined:

Agency administration costs include all the administrative costs that are not directly related to specific programs/sites but are attributable to the overall operation of the agency such as:

- costs for the overall direction of the organization;
- costs for general record keeping, budget and fiscal management;
- costs for governing board activities;
- costs for public relations (*excluding fund raising and special events)*; and
- costs for parent agency expenses.

which may include but are not limited to the following:

- Personal service costs of agency administrative staff (i.e., Executive Director, Comptroller, Personnel Director, etc.)
- Leave accruals and fringe benefits corresponding to the personal services listed above
- Other than personal services costs (OTPS) costs associated with agency administration activities (i.e., telephone, repairs and maintenance, utilities)
- Agency-wide auditing costs for independent licensed or certified public accountants. (Note that agency-wide auditing costs cannot be directly charged as program costs on CFR-1.)
- Depreciation and/or lease costs associated with vehicles and equipment used by agency administration staff.
- Depreciation and/or lease costs associated with space occupied by agency administrative offices.

Agency administration costs do not include fundraising costs and special events costs. Fundraising and special events costs are reported on Schedule 2 in column 7 under “Other Programs”.

Agency administration costs do not include program/site specific costs or program administration costs. Program/site costs are costs directly associated with the provision of services and are included on the appropriate line of expense on Schedules CFR-1 (lines 16 through 63), DMH-1 (lines 6 through 11) and DMH-2 (lines 5 through 10). *Program administration costs* are administrative costs which are directly attributable to a specific program/site (i.e., personal services and fringe benefits of Billing Personnel, Program Director, Program Coordinator, etc.) and are to be included on the appropriate line of expense on CFR-1 (lines 16 through 63), DMH-1 (lines 6 through 11) and DMH-2 (lines 5 through 10). The program administration level of administration may not be applicable to all service providers. However, all service providers must report agency administration.

County operated service providers should note that Local Governmental Unit (LGU) Administration costs are reported as a shared program using program code 0890 on the applicable Schedules CFR-1 through CFR-6 and DMH-1. (Refer to Appendix K.)

Service Providers should note that *all attempts should be made to directly charge an expense* to the appropriate cost center (agency administration or program/site and program administration). If you are unable to direct charge expenses to agency administration or program/site(s) and program administration, the following includes examples of recommended allocation methods:

Expense Item	***Recommended Allocation Method***
Repairs and Maintenance	Square Footage
Utilities	Square Footage
Staff Travel	Full-Time-Equivalents
Telephone	Number of Lines
Building Depreciation	Square Footage
Building Lease Costs	Square Footage
Mortgage Interest	Square Footage

Property Costs Relating to Agency Administrative Offices:

If agency administrative offices and program offices are located in the same building, property related costs must be allocated using square footage as the statistical basis. These costs include expenses such as utilities, repairs and maintenance, depreciation, leases or mortgage interest. Square footage cost allocations must be calculated using the following procedure (square footage should be the interior square footage):

1. Determine the number of square feet which is used exclusively by agency administrative offices and each program or program/site, not shared in common.
2. Determine the number of square feet which is shared in common, i.e., lobby, restrooms, conference areas, etc.
3. Calculate an allocation ratio by dividing each exclusive square footage amount by the total amount less the commonly shared amount.
4. Multiply each respective cost by the allocation ratios to determine the allocated dollar amount.

Example: Program A and Agency Administrative Offices occupy the same building. Utility expenses of $5,000 must be allocated to Program A and to the Agency Administrative Offices as follows:

Step 1 - Exclusive square feet - Program A = 500 sq. ft.
Exclusive square feet - Agency Administrative Offices = 300 sq. ft.
Step 2 - Common Square feet - 1,000 sq. ft.
Total Square Feet - 1,800 sq. ft.
Step 3 - Program A = 500/(1,800-1,000) = .625
Agency Administrative Offices = 300/(1,800-1,000) = .375
Step 4 - Utility Expenses for this particular building total $5,000

Utility expenses allocated to Program A = $5,000 X .625 = $3,125
Utility expenses allocated to Agency Admin. Offices = $5,000 X .375 = $1,875

Property related expenses and revenues that do ***not*** pertain to your agency's DMH programs, SED programs and agency administration must be reported in the "Other Programs" column (column 7) of Schedule CFR-2.

Allocation of Total Agency Administration Costs to Program/sites:

To ensure equity of distribution and to provide uniformity in allocation of agency administration, OASAS, OMH, OMRDD, and SED require the *ratio value* (R/V) method of allocation to be used on the core CFR schedules (CFR-1 through CFR-6). The ratio value method uses operating costs as the basis for allocating agency administration expenses. Agency administration expenses must be allocated to programs operated by OASAS, OMH, OMRDD and SED as well as shared programs and "Other Programs" (includes fundraising, all programs funded by non-CFRS participating State agencies, etc.) based upon the ratio of agency administration costs to the service provider's total operating costs.

The calculation of operating costs and the allocation of agency administration to program/sites is determined on page 2 of Schedule CFR-3. The operating costs used to allocate agency administration operating costs are calculated first on an agency-wide basis and then within each state agency. Operating costs include personal services, leave accruals, fringe benefits and OTPS. Operating costs do not include equipment, property and raw materials.

The agency-wide operating costs (CFR-3, lines 43 through 49) do not include the expenses of programs 0190 and 0890. In determining the operating costs within a state agency, the expenses for certain additional programs are deducted from the agency-wide operating costs. The resulting adjusted operating cost totals are entered on CFR-3, lines 60 through 64. Operating expenses for the following programs are to be deducted from agency-wide operating costs (CFR-3, lines 43 through 49):

- For OMH, operating expenses for programs coded 0860, 0870, 1690, 2820, 2830, 2860, 8810 and programs with an "A" program code index (startup) are deducted from CFR-3, line 44. The adjusted total is entered on CFR-3, line 61.
- For OMRDD, operating expenses for programs coded 2091 and 5091 are deducted from CFR-3, line 45. The adjusted total is entered on CFR-3, line 62.
- For SED, operating expenses for programs coded 9800-9810 are deducted from CFR-3, line 46. The adjusted total is entered on CFR-3, line 63.

The following is an example of how to calculate operating costs, the ratio value factor and the amount of agency administration costs that should be allocated to programs using the ratio value method of allocation.

Provider XYZ reports the following program/site and program administration expenses:

Program	OASAS	OMH	OMRDD	SED	Shared	Other	Total
From Schedule	CFR-1	CFR-1	CFR-1	CFR-1	CFR-1	CFR-2	
Personal Services	154,000	230,500	840,000	450,000	155,000	60,000	$1,889,500
Vacation Accruals	-7,700	11,500	4,200	22,500	7,600	3,000	$56,500
Fringe Benefits	38,500	57,700	210,000	112,500	38,700	15,000	$472,400
OTPS	71,000	185,000	425,000	225,000	63,000	35,000	$1,004,000
Equipment	3,200	2,500	7,200	5,900	2,900	1,500	$23,200
Property	23,000	18,000	55,000	30,000	27,000	5,800	$158,800
Total Before Administration Allocation	297,400	505,200	1,541,400	845,900	294,200	120,300	$3,604,400

Provider XYZ reports program/site and program administration expenses for the following OMH programs:

OMH Program	2100	2830	Total
From Schedule*	CFR-1	CFR-1	
Personal Services	230,500	0	$230,500
Vacation Accruals	11,500	0	$11,500
Fringe Benefits	57,700	0	$57,700
OTPS	110,000	40,000	$185,000
Operating costs	409,700	40,000	$484,700

For this example, assume page 1 of Schedule CFR-3, Agency Administration, line 42 reflects net agency administration of $650,400. Net agency administration must be allocated to all programs using the ratio value method which is based on operating costs. Operating costs include personal services, vacation accruals, fringe benefits and OTPS (less sub-contract raw materials - CFR-1, line 29). Based on the information reported above, operating costs are calculated as follows:

Program	OASAS	OMH	OMRDD	SED	Shared	Other	Total
From Schedule	CFR-1	CFR-1	CFR-1	CFR -1	CFR-1	CFR-2	
Personal Services	154,000	230,500	840,000	450,000	155,000	60,000	$1,889,500
Vacation Accruals	7,700	11,500	4,200	22,500	7,600	3,000	$56,500
Fringe Benefits	38,500	57,700	210,000	112,500	38,700	15,000	$472,400
OTPS	71,000	185,000	425,000	225,000	63,000	35,000	$1,004,000
Operating costs	271,200	484,700	1,479,200	810,000	264,300	113,000	$3,422,400

**Abbreviated filers must obtain these amounts from their general ledger.*

The Agency-wide Ratio Value Worksheet on the left hand side of page 2 of Schedule CFR-3 should reflect the information shown below. At the Agency-wide level, program expenses for programs coded 0190 and 0890 are excluded from the operating costs. The figure shown on line 44 below is calculated as follows: $484,700 (total operating costs for OMH programs) minus $35,000 (total operating costs for the program coded 0880) = $449,700.

Line No.	***State Agency***	***Amount***
Calculation of Operating Costs		
43	OASAS Subtotal	271,200
44	OMH Subtotal	449,700
45	OMRDD Subtotal	1,479,200
46	SED Subtotal	810,000
47	Shared Programs Subtotal	264,300
48	Other Programs Subtotal	113,000
49	Total Agency Operating Costs	3,387,400
Calculation of Ratio Value Factor		
50	Net Agency Administration (CFR-3, line 42)	650,400
51	Total Agency Operating Costs (CFR-3, line 49)	3,387,400
52	Ratio Value Factor (Line 50 divided by line 51)	.192006
Allocation of Agency Administration Using Ratio Value		
53	OASAS Allocation (line 43 x line 52)	52,072
54	OMH Allocation (line 44 x line 52)	86,345
55	OMRDD Allocation (line 45 x line 52)	284,015
56	SED Allocation (line 46 x line 52)	155,524
57	Shared Programs Allocation (line 47 x line 52)	50,747
58	Other Programs Allocation (line 48 x line 52)	21,697
59	Total Agency Administration (sum lines 53 – 58)	650,400

The Ratio Value Worksheet within State Agency on the right hand side of page 2 of Schedule CFR-3 should reflect the information shown below. To arrive at the adjusted totals, expenses for OMH programs coded 0860, 0870, 1690, 2820, 2830, and programs with an “A” program code index (startup) are deducted from CFR-3, line 44. Also, expenses for OMRDD programs coded 2091, 5091, and 7091 are deducted from CFR-3, line 45 and expenses for SED programs coded 9800-9810 are deducted from CFR-3, line 46. In this example, the only additional program that is exempt from the allocation of agency administration within state agency is the OMH is the program coded 2830. The figure shown on line 61 below is calculated as follows: $449,700 (total operating costs for OMH programs) minus $40,000 (total operating costs for the program coded 2830) = $409,700.

Line No.	*State Agency*	*Operating Costs*
Calculation of Adjusted Operating Costs		
60	OASAS Adjusted Subtotal	271,200
61	OMH Adjusted Subtotal	409,700
62	OMRDD Adjusted Subtotal	1,479,200
63	SED Adjusted Subtotal	810,000
64	Shared Programs Adjusted Subtotal	264,300
Calculation of Adjusted Ratio Value Factor (transfer to the item description col. Of line CFR-1, line 65)		
65	OASAS Allocation (line 53 divided by line 60)	.192006
66	OMH Allocation (line 54 divided by line 61)	.210752
67	OMRDD Allocation (line 55 divided by line 62)	.192006
68	SED Allocation (line 56 divided by line 63)	.192006
69	Shared Programs Allocation (line 57 divided by line 64)	.192006

The Adjusted Ratio Value Factor calculated on lines 65 through 69 of CFR-3, is transferred to the item description column of CFR-1, line 65. Please note that the Adjusted Ratio Value Factor may be different for each of the state agencies, depending on whether or not the state agency has programs that are exempt from administration at the state agency level.

To allocate the agency administration expense to program/sites by State agency on CFR-1, line 65, multiply each program/site's total operating costs (reported on line 64 of Schedule CFR-1) by the Adjusted Ratio Value Factor. An amount for agency administration is not entered on CFR-1, line 65, for programs that are exempt from agency administration allocation.

In this example, the three program/sites funded by OMH would be allocated agency administration expenses as follows:

CFR-1 Line #	16	17	20	41	64	65
Expense	Personal Services	Vacation Accruals	Fringe Benefits	OTPS	Total Operating costs	Agency Administration Allocation (line 64 times .210752)
OMH 0880 Program	$0	0	0	35,000	35,000	$0
OMH 2100 Program	$230,500	11,500	57,700	110,000	409,700	$86,345
OMH 4810 Program	$0	0	0	40,000	40,000	$0
Total OMH Programs	$230,500	11,500	57,700	185,000	484,700	$86,345

Service providers should refer to Section 20 for more specific instructions for claiming agency administration costs.

The following guidelines are to be used only after all attempts have been made to direct charge an expense.

These guidelines are for allocating program costs, *exclusive of agency administration,* when a program serves more than one State agency, or when more than one program shares the same item of expense. Examples are given utilizing shared staff, capital and general operating costs as the major categories of expense.

Shared Staff

Actual hours of service is the preferred statistical basis upon which to allocate salaries and fringe benefits for staff which are jointly shared between State agencies, or work at multiple program/sites. Providers must maintain appropriate documentation reflecting the hours used in this allocation. Acceptable documentation may include payroll records or time studies. SED providers should use the data compiled on Schedule SED-4 to report CFR-4 and CFR-4A information for direct care related service staff. (Refer to Appendix L to determine what constitutes an acceptable time study).

Example 1: Agency XYZ employs a direct care worker who works at two separate community residences. The standard work week for this person is forty (40) hours. Payroll records indicate 25 hours/week are spent at Site A and 15 hours/week at Site B. This person's salary and fringe benefits are allocated as follows:

Site A - $16,200 (annual salary and fringe) X (25/40) = $10,125
Site B - $16,200 (annual salary and fringe) X (15/40) = $ 6,075

Example 2: Agency XYZ operates a sheltered workshop program which is funded by more than one State agency. They employ a social worker within this program and cannot determine the direct hours of service provided by funding source. The provider can, however, determine the number of units of service provided during the cost report period by funding source. (OMRDD = 7,500 units, OMH = 5,000 units, Other = 2,500 units). This person's salary and fringe are allocated as follows:

OMRDD - $24,000 (annual salary and fringe) X 7,500/15,000 (units/total units) = $12,000

OMH - $24,000 (annual salary and fringe) X 5,000/15,000 (units/total units) = $ 8,000

Other - $24,000 (annual salary and fringe) X 2,500/15,000 (units/total units) = $ 4,000

Example 3: Agency XYZ employs a social worker who works at two clinic treatment programs. The social worker must maintain a time study to properly allocate time to the proper program (See Appendix L). His/her actual hours worked were not maintained.

Social Worker salary: $20,000

Per time study, the social worker spent 20% of his/her time at Site A and 80% at Site B.

Site A - $20,000 (annual salary and fringe) X 20% = $ 4,000
Site B - $20,000 (annual salary and fringe) X 80% = $16,000

Example 4: Agency XYZ has a clinic treatment program which is funded by Aid to Localities and Community Support Services (CSS). The staff members treat both CSS and Local Assistance clients. Only one general ledger account is maintained for the Clinic Program. Therefore, their salary cost will be allocated based on units of service.

Step 1 - Percentage Calculation	***Units of Service***	***Percentage***
Local Assistance	1,000	33.3%
CSS	2,000	66.7%
Total Clinic Treatment	3,000	100%
Step 2 - Cost Allocation	CSS	*Local Assistance*
Clinic Treatment Personal Service Cost	$100,000	$100,000
Percentage	66.7%	33.3%
Clinic Treatment Personal Service Cost by Funding Source	$66,700	$33,300

Capital and Related Costs

When programs share the same geographic location or more than one State agency is served at the same geographic location, property and related costs must be allocated using square footage as the statistical basis. These costs include expenses such as utilities, repairs and maintenance, depreciation, leases or mortgage interest. Square footage cost allocations must be calculated using the following procedure: (square footage should be the interior square footage).

1. Determine the number of square feet which is used exclusively by each program or State agency, i.e., not shared in common.

2. Determine the number of square feet which is shared in common, i.e., lobby, restrooms, conference areas, etc.

3. Calculate an allocation ratio by dividing each exclusive square footage amount by the total site amount less the commonly shared amount.

4. Multiply each respective cost by the allocation ratios to determine the allocated dollar amount.

Example:

Step 1	Exclusive square feet	-	Program A = 500 sq. ft.
	Exclusive square feet	-	Program B = 300 sq. ft.
Step 2	Common Square Feet	-	1,000 sq. ft.
	Total Site Square Feet	-	1,800 sq. ft.
Step 3	Program A = 500/(1,800-1,000)	=	.625
	Program B = 300/(1,800-1,000)	=	.375
Step 4	Program A Allocation = $5,000 X .625	=	$3,125
	Program B Allocation = $5,000 X .375	=	$1,875

If all space is shared in common, then the allocation ratio should be calculated based upon the full units of service provided in each program or State agency to the total full units of service provided at the location.

Example: A workshop program serves both OMH and OMRDD participants. The space used is common to both State agencies. Therefore, the following allocation basis is utilized:

OMH Full Units of Service = 50	50/150 = .3333
OMRDD Full Units of Service = 100	100/150 = .6667
Total Full Units of Service = 150	150 = 1.000
Rent Expense: $10,000 OMH = $10,000 X .3333 = $3,333 OMRDD = $10,000 X .6667 = $6,667	

General Operating Expense

Expenses such as food, transportation, supplies and material, staff travel and training, etc. which cannot be directly charged to a specific program or State agency must be allocated across all such entities deriving benefits. If you are unable to direct charge expenses to agency administration or program/site(s), you may use the following recommended allocation methods for each specific OTPS item:

OTPS Item	*Recommended Allocation Method*
Food	Meals Served
Repairs and Maintenance	Square Feet
Utilities	Square Feet
Transportation Related	Number of Trips or Mileage
Staff Travel	Full-Time-Equivalents
Participant Incidentals	Direct Charge Only
Expensed Equipment	Units of Service if the item is shared by more than one State agency or program site.
Subcontract Raw Materials	Direct Charge Only
Participant Wages	Direct Charge Only
Staff Development	Full-Time-Equivalents
Supplies and Materials	Units of Service
Telephone	Number of Lines
Insurance-General	Ratio Value
Other	Units of Service

If the recommended allocation method does not apply, the provider should determine a more reasonable method of allocation. Example: A service provider needs to allocate supplies and materials costs to several program/sites. The recommended allocation method noted above is units of service. However, all the program/sites do not report units of service. In this case, a more reasonable method of allocating supplies and materials would be to allocate the cost based on usage.

Local Governmental Unit Administration (LGU) is considered a unique cost center over and above the cost to the agency as a service provider; therefore, a separate cost center should be maintained for LGU administration detailing personal services and other than personal services costs. LGU administration costs are required to be reported as a shared program (program code 0890) on the core CFR schedules (CFR-1 through CFR-6) and DMH-1. The journal entries should be made during the provider's normal accounting cycle. The following is a summary list of activities from Section 41.13 of the Mental Hygiene Law (MHL) which are associated with the responsibility of the LGU. Refer to the MHL for a complete description of each activity.

- Review services and local facilities for the mentally disabled of the area which it serves and their relationship to local need; determine needs of the mentally disabled of such area; and encourage programs of prevention, diagnosis, care, treatment, social and vocational rehabilitation, special education and training, consultation, and public education on mental disabilities.

- Develop a program of local services for the area which it serves, establish long-range goals of the local government in its programs for the mentally disabled, and develop intermediate range plans and forecasts, listing priorities and estimated costs.

- Direct and administer the development of a local comprehensive plan for all services for mentally disabled residents of the area, which shall be submitted to the department and used in part to formulate a statewide comprehensive plan for services.

- Seek to assure that under the goals and plans required, all population groups are adequately covered, sufficient services are available for all the mentally disabled within its purview, that there is coordination and cooperation among local providers of services, that the local program is integrated and coordinated with the programs of the department, and that there is continuity of care among all providers of services.

- Submit annually to the department for its approval and subsequent State Aid, a report of long-range goals and specific intermediate range plans as modified since the preceding report, along with a local services plan or unified services plan for the next fiscal year.

- Have the power, with the approval of local government, to enter into contracts for the provision of services and the construction of facilities including contracts executed pursuant to subdivision (e) of section 41.19 of this article and the power, when necessary, to approve construction projects.

- Establish procedures for execution of local government, to enter into contracts for the provision of services and the construction of facilities including regulations to guide the provision of services by all organizations and individuals within its program.

- Make policy for and exercise general supervisory authority over or administer local services and facilities provided or supervised by it whether directly or through agreements, including responsibility for the proper performance of the services provided

by other facilities of local government and by voluntary and private facilities which have been incorporated into its comprehensive program. Serve as a center for the promotion of community and public understanding of mental disabilities and of the services necessary for their care and treatment.

- Seek the cooperation and cooperate with other public health and social services agencies, public and private, in advancing the program of local or unified services.

- Further programs for special education and training, including career incentive and manpower and development.

- Have the power to conduct or contract for such research as may be useful for the discharge of its administrative duties and for the promotion of scientific knowledge of the mental disabilities.

- Have the powers necessary and proper for the effective performance of its functions and duties.

- Require the development of a written treatment plan as provided in rules and regulations of the commissioner.

- The local governmental unit for the county of Westchester shall establish a volunteer ombudsman pilot program within its territorial jurisdiction.

The preceding list should enable a service provider to determine between agency administration functions (e.g., executive director) and LGU functions.

A separate cost center should be set up for LGU administration on the LGU's general ledger. If this is not feasible, the following procedures must occur:

Personal Services

First, determine all personnel who spent 100% of their time on LGU administration.

For personnel who spent less than 100% of their time on LGU, a time study must be performed to properly allocate their time (refer to the guidelines for an acceptable time study in Appendix L).

Fringe Benefits

Applicable fringe benefits to employees who are working in LGU administration should be detailed as follows:

Example:

i.	Fringe Benefits	$150,000
ii.	Total Personal Services	1,500,000
iii.	Fringe Benefit Percentage (line i. line ii)	.10
iv.	Joe Smith's Salary	50,000
v.	Fringe Benefits Applicable to Joe Smith (line iii x line iv)	5,000
vi.	Percentage of Time Related to LGU	10%
vii.	Personal Service Cost Related to LGU (line iv x line vi)	5,000
viii.	Fringe Benefits Applicable to LGU (line v x line vi)	500

Other Than Personal Services

First, determine if the cost related to LGU administration can be identified separately. The cost would include:

Professional Fees - Auditing and Accounting, Payroll Processing, Corporate Legal & Management Consulting, Investment Counseling, Public Relations and Advertising.

Employment Recruiting - Help Wanted Advertising, Employment Agency Fees, Costs of Temporary Office Help.

Supplies - General Supplies, Postage and Shipping Charges, EDP Software and Supplies, Cleaning and Maintenance Supplies.

Travel - Airfare, Train, Program Vehicle Operating Expenses (Insurance Registration, Fuel, Repairs), Conferences/Convention Costs for Program Staff.

Equipment - Depreciation, Interest, Lease Expenses for Fixed Major Moveable and Minor Equipment, Repair and Maintenance Expenses of Equipment.

Property - Repairs and Maintenance, Insurance, Taxes, Utilities, Rental/Lease, Depreciation Building Improvement, Leasehold Expenses and Improvements, Mortgage Interest (do not include principal amounts).

Other - Other expenses related to the administration of the program not reported above. These should be reported by item of expense.

Service providers may be requested to submit the County Wide Cost Allocation Plan. This plan is prepared and certified by an independent, licensed or certified public accountant. This plan must include a listing of the type of service, amount and allocation base.

If LGU other than personal service costs are included with agency administration because the employee is only working a portion of their time on LGU administration, the following approach is required:

Determine the total amount of LGU personal service and fringe benefit costs; then divide that amount by the sum of your agency administration and LGU personal service and fringe benefits cost to determine the percent of LGU personal service and fringe benefits related to LGU administration. This percentage would be multiplied times other than personal service cost (e.g., OTPS, equipment and property cost) related to agency administration to determine total other than personal service cost related to LGU administration.

Example:

1.	Total LGU personal service and fringe benefits	$120,000
2.	Total agency administration and LGU personal services and fringe benefits (includes LGU)	450,000
3.	Percentage of LGU personal service and fringe benefit cost to total agency administration and LGU (line 1. line 2)	.2667
4.	Total agency administration and LGU OTPS costs	525,000
5.	Portion of OTPS cost related to LGU administration (line 3 x line 4)	140,018
6.	Total agency administration and LGU equipment cost	25,000
7.	Portion of equipment cost related to LGU administration (line 3 x line 6)	6,668
8.	Total agency administration and LGU property cost	120,000
9.	Portion of property cost related to LGU administration (line 3 x line 8)	32,004
10.	*Total cost related to LGU Administration cost (lines 1, 5, 7 and 9)*	*$298,690*

Please refer to Volume XI, Section 6.04 (Special Payments – Municipal Overhead Costs) of the New York State Accounting System User Procedures for more clarification on the reimbursement of LGU administration costs. (A copy of Section 6.04 can be found on page 35.9.)

Following is a listing of the allocated percentages between the DMH agencies for all counties for the LGU administration expenses and revenues. These should be used when preparing your budgets and claims.

Department of Mental Hygiene
County Administration Percentage Splits as Calculated In 1988

Counties		***OASAS Percentage***	***OMH Percentage***	***OMRDD Percentage***	***Total 620/REG as % of Total***
Albany	Total	37.49	36.09	26.42	100.00
	620			100.00	4.33
	OT620	39.19	37.72	23.09	95.67
Allegany	Total	29.30	24.08	46.62	100.00
	620				0
	OT620				100.00
Broome	Total	26.77	28.37	44.86	100.00
	620				0
	OT620				100.00
Cattaraugus	Total	8.74	16.61	74.65	100.00
	620				0
	OT620				100.00
Cayuga	Total	.89	14.50	84.61	100.00
	620				0
	OT620				100.00
Chautauqua	Total	51.90	48.10	0	100.00
	620				0
	OT620				100.00
Chemung	Total	17.53	32.79	49.68	100.00
	620			100.00	9.34
	OT620	19.33	36.18	44.49	90.66
Chenango	Total	7.88	21.57	70.55	100.00
	620				0
	OT620				100.00
Clinton	Total	7.32	41.95	50.73	100.00
	620			100.00	9.90
	OT620	8.12	46.56	45.32	90.10
Columbia	Total	6.00	20.00	74.00	100.00
	620		0	100.00	37.00
	OT620	9.52	31.75	58.73	63.00
Cortland	Total	21.13	29.36	49.51	100.00
	620				0
	OT620				100.00
Delaware	Total	13.14	14.07	72.79	100.00

Counties		*OASAS Percentage*	*OMH Percentage*	*OMRDD Percentage*	*Total 620/REG as % of Total*
	620			*100.00	25.70
	OT620	17.68	18.94	63.38	74.30
Dutchess	Total	17.40	40.00	42.60	100.00
	620		0	100.00	18.75
	OT620	21.41	49.22	29.37	81.25
Erie	Total	30.55	51.64	17.81	100.00
	620			*100.00	8.66
	OT620	33.44	56.54	10.02	91.34
Essex	Total	20.44	20.82	58.74	100.00
	620				0
	OT620				100.00
Franklin	Total	9.55	11.50	78.95	100.00
	620				0
	OT620				100.00
Fulton	Total	34.06	57.40	8.54	100.00
	620				0
	OT620				100.00
Genesee	Total	19.19	33.82	46.99	100.00
	620				0
	OT620				100.00
Greene	Total	6.12	31.76	62.12	100.00
	620			100.00	1.83
	OT620	6.24	32.35	61.41	98.17
Hamilton	Total	34.68	38.16	27.16	100.00
	620				0
	OT620				100.00
Herkimer	Total	39.02	57.76	3.22	100.00
	620				0
	OT620				100.00
Jefferson	Total	22.70	72.21	5.09	100.00
	620				0
	OT620				100.00
Lewis	Total	9.33	27.06	63.61	100.00
	620				0
	OT620				100.00
Livingston	Total	100.00	0	0	100.00
	620	0	0	0	0
	OT620	100.00	0	0	100.00
Madison	Total	14.80	21.66	63.54	100.00
	620				0
	OT620				100.00

Counties		*OASAS Percentage*	*OMH Percentage*	*OMRDD Percentage*	*Total 620/REG as % of Total*
Monroe	Total	0	73.34	26.66	100.00
	620	0	0	100.00	2.58
	OT620	0	75.28	24.72	97.42
Montgomery	Total	41.61	58.39	0	100.00
	620				0
	OT620				100.00
Nassau	Total	0	92.90	7.10	100.00
	620				0
	OT620				100.00
Niagara	Total	22.12	56.09	21.79	100.00
	620				0
	OT620				100.00
Oneida	Total	23.82	25.91	50.27	100.00
	620				0
	OT620				100.00
Onondaga	Total	24.44	36.59	38.97	100.00
	620			100.00	11.46
	OT620	27.61	41.32	31.07	88.54
Ontario	Total	9.85	32.45	57.70	100.00
	620				0
	OT620				100.00
Orange	Total	14.99	46.41	38.60	100.00
	620			100.00	12.50
	OT620	16.87	52.21	30.92	87.50
Orleans	Total	13.95	14.02	72.03	100.00
	620				0
	OT620				100.00
Oswego	Total	4.05	44.10	51.85	100.00
	620				0
	OT620				100.00
Otsego	Total	12.72	16.01	71.27	100.00
	620				0
	OT620				100.00
Putnam	Total	16.37	57.71	25.92	100.00
	620				0
	OT620				100.00
Rensselaer	Total	10.25	55.23	34.52	100.00
	620				0
	OT620				100.00
Rockland	Total	13.56	56.62	29.82	100.00

Counties		*OASAS Percentage*	*OMH Percentage*	*OMRDD Percentage*	*Total 620/REG as % of Total*
	620			100.00	9.30
	OT620	14.95	62.43	22.62	90.70
St. Lawrence	Total	58.55	27.08	14.37	100.00
	620				0
	OT620				100.00
Saratoga	Total	20.67	30.64	48.69	100.00
	620				0
	OT620				100.00
Schenectady	Total	19.20	17.90	62.90	100.00
	620				0
	OT620				100.00
Schoharie	Total	18.92	15.89	65.19	100.00
	620				0
	OT620				100.00
Schuyler	Total	22.81	25.10	52.09	100.00
	620				0
	OT620				100.00
Seneca	Total	19.93	38.14	41.93	100.00
	620				0
	OT620				100.00
Steuben	Total	39.84	20.37	39.79	100.00
	620				0
	OT620				100.00
Suffolk	Total	**	68.71	31.29	100.00
	620			100.00	.72
	OT620		69.20	30.80	99.28
Sullivan	Total	20.03	32.60	47.37	100.00
	620			100.00	4.95
	OT620	21.07	34.30	44.63	95.05
Tioga	Total	9.21	42.34	48.45	100.00
	620				0
	OT620				100.00
Tompkins	Total	10.49	26.81	62.70	100.00
	620				0
	OT620				100.00
Ulster	Total	12.63	42.84	44.53	100.00
	620			100.00	20.80
	OT620	15.94	54.09	29.97	79.20
Warren	Total	7.50	52.90	39.60	100.00
	620				0
	OT620				100.00

Counties		*OASAS Percentage*	*OMH Percentage*	*OMRDD Percentage*	*Total 620/REG as % of Total*
Washington	Total	8.40	58.10	33.50	100.00
	620				0
	OT620				100.00
Wayne	Total	28.74	12.34	58.92	100.00
	620				0
	OT620				100.00
Westchester	Total	11.34	69.53	19.13	100.00
	620			100.00	1.94
	OT620	11.57	70.90	17.53	98.06
Wyoming	Total	36.53	63.47	0	100.00
	620				0
	OT620				100.00
Yates	Total	0	33.83	66.17	100.00
	620				0
	OT620				100.00

** Methodology exception for Chapter 620, actual expenditures for Chapter 620.*

***Currently, separate OASAS administration may be changing back to Health Services.*

The following is from the New York State Office of the State Comptroller and can be found in Volume XI, Section 6.04 (Special Payments – Municipal Overhead Costs) of the New York State Accounting System User Procedures Manual.

> *The Federal Office of Management and Budget's Circular 74-4 (originally issued as Circular A-87, 1968) issued in December 1976, established standards for reimbursing state and local governments for overhead costs incurred in administering Federally funded programs. The principle set forth in the circular is that the Federal government should reimburse state and local governments for the total costs of administering Federal programs, except where restricted or prohibited by law,*
>
> *In the case of local governments, the circular applies only to overhead cost reimbursements to the locality by the Federal government, It does not apply to State-financed programs and does not obligate the State to change any of its policies regarding reimbursements to localities for State-aided programs, For example, such local administrative costs as legal services, personnel, budgeting, accounting, chief executives office, etc, are not automatically eligible for State aid,*

Local administrative costs may be eligible for State aid reimbursement subject to the following conditions which have been agreed to by OSC and the State Division of the Budget. The conditions are:

1. *Payment for these costs cannot be made unless they were contemplated in the program costs set forth in the State's Executive Budget and approved by the State Legislature,*

2. *The extent to which the State may want to participate in a particular-program will depend upon the availability of funds in the light of other priorities. Therefore, the addition of central staff overhead may result in a decision to lower the percentage contribution by the State.*

All personnel who work in more than one program should allocate their salary to the proper cost center during the normal accounting cycle based on actual time and attendance records. If this does not occur, the service provider must complete a time study for each employee who works in more than one program. Following are criteria for an acceptable time study. These criteria are the minimum standards. If necessary, a service provider can expand the length of the time study.

- A minimally acceptable time study must encompass at least two weeks per quarter of the cost reporting period.
- Each week selected must be a full week (Monday to Friday, Monday to Saturday, or Sunday to Saturday).
- The weeks selected must be equally distributed among the months of the cost reporting period, e.g., week 3 and 4 in March, week 2 and 3 in June, week 3 and 4 in September, and week 1 and 2 in December.
- No two consecutive quarters may use the same weeks for the study, e.g., week 1 and 2 in March and June.
- The time study must be contemporaneous with the costs to be allocated. Thus, a time study conducted in the current cost reporting year may not be used to allocate the costs of prior or subsequent cost reporting years.
- The time study must be provider specific.

This Appendix is not applicable for OMH, OMRDD and SED. OMH providers should refer to Part 587 and 588 of New York State Codes, Rules and Regulations.

The following rules have been established to reduce variation in service volumes due to inter-facility differences in organizational structure, operational interpretation of definitions, counting procedures and criteria for admitting family members. Relevant definitions follow this section.

The rules below apply to statistical reporting. Rules for billing Medicaid and most other third-party payors are more restrictive.

The following rules for counting visits apply to each program/site of the service provider.

Rule 1. A person (participant, client, collateral or significant other) can have no more than one full visit to a given program in a day (midnight to midnight).

Rule 2. A person can have a community residence day and, in addition, a visit to a non-residential program in the same day.

Rule 3. No combination of visits may add up to more than one full day visit. For example, a participant may have up to two half day visits to a program, but not a full day visit and another kind of visit.

Rule 4. When a participant attends a given program, then leaves and returns for a second attendance in the same day, the time of the two (or more) attendances must be cumulated and the visit reported as a single visit to that program.

Rule 5. If a client/participant and collateral or significant other are seen the same day, separate visits may be counted provided:

1. The collateral or significant other participates actively in the program and does not merely accompany or wait for the patient.

2. The collateral or significant other's participation is adequately documented in facility/unit records.

Rule 6. Only one visit to a program may be reported even when the participant receives more than one procedure or service or is served by more than one staff member or discipline during a visit.

Rule 7. Except for pre-admission screening, a participant and collateral or significant other visit may not be counted unless the patient is on the facility/unit rolls.

Rule 8. A visit is a face-to-face contact between a participant and a clinician whether singularly or in a group. For a group session, therefore, each individual should be counted as having a visit.

The following is a listing of the funding source codes to be used on Schedule DMH-3 by all DMH providers. OMH only index codes and OMH only Community Reinvestment codes are also listed.

***Note: OASAS providers must indicate the source of funds (S, M, O, F, C, P) consistent with their most recent approved budget in the funding source code index field.**

DMH Code #	OMH Only Index	Description
001		**Local Assistance - Regular State/Federal** - (OASAS, OMH, OMRDD) (Article 41, Section 18(b), Title E, MHL). Local governments are granted State Aid for approved net operating costs pursuant to an approved local services plan at the rate of 50% of the amount incurred during the local fiscal year by the local governments and volunteer agencies pursuant to a contract. **Unified Services Plan Financing** - (OASAS, OMH, OMRDD) (Article 41, Section 23(a)(b)(c)(d), Title E, MHL). Aggregate costs incurred pursuant to an approved unified services plan are funded according to provisions in Section 23. (See Section G DMH-2 for unified services rates). **OMH service providers using funding source code 001 must also indicate the funding source index in the funding source code index field on DMH-3.**
001	**A**	**Adults** - (OMH Only)
004		**Chapter 620** - (OMRDD) (Article 41, Section 18(b), Title E, MHL) Local governments having a contract to provide services to persons who were patients in a State facility for a period of five or more years following January 1, 1969 are granted State Aid at the rate of 100% of approved net operating expenses.
005		**Chapter 620 Direct Contract** - (OMRDD) (Article 41, Section 18(b), Title E, MHL) Voluntary agencies having direct contracts with an office of the department to provide Chapter 620 services are granted State Aid at the rate of 100% of approved net operating expenses.
013		**Continual 100% Net Deficit - State/Federal** - (OASAS) State Aid may be provided to local governments and to voluntary agencies in an amount up to 100% of the approved net operating cost for the delivery of jointly certified residential services to chemically dependent youth, certified community residential beds, certified alcoholism crisis services and innovative treatment and prevention programs pursuant to legislation and approved local services or unified services plans.

DMH Code #	OMH Only Index	Description
014		**Community Support Services** - (OMH) The CSS program provides a variety of outpatient mental health services to the seriously and persistently mentally ill who meet CSS eligibility requirements. The program is operated through approval letters with counties and direct contracts between OMH and voluntary agencies. Approved costs are funded at the rate of 100% State participation.
020		**Direct Sheltered Workshop** - (OMH, OMRDD) (Article 41, Section 39, Title E, Mental Hygiene Law). Voluntary not-for-profit agencies who receive income through the operation of a sheltered workshop or industrial contract may have that income matched dollar-for-dollar through direct contract. However, eligibility for this assistance requires that no part of the expenses of the workshop be claimed through a contract with the local governmental unit. No combination of income including State Aid can exceed the total cost of operation of the workshop.
021		**Direct Local Assistance** - (OMH, OMRDD) (Article 41, Section 13(e), Title E, Mental Hygiene Law). Voluntary agencies having direct contracts with an office/division of the department are granted State Aid for approved net operating costs for services provided in accordance with an applicable local services plan at the rate of 50% of the amount incurred during the local fiscal year.
022		**Day Training Projects** - (OMRDD)
024		**SOICF Day Training** - (OMRDD) Agencies are provided State Aid up to 100% of the net operating costs related to the provision of SOICF Day Training services to SOICF services consumers.
029		**Special Legislative Grants** - (OMRDD only) (Article 41, Section 37, Title E, Mental Hygiene Law). Self-explanatory.
031		**Program Development Grants** - (OMH, OMRDD) (Article 41, Section 37, Title E, Mental Hygiene Law). Local governmental units and voluntary not-for-profit agencies are eligible for grants for up to 100% reimbursement for development costs of a community residence or residential treatment facility (RTF) incurred prior to the operation of the community residence or RTF. These costs may include: - Reasonable legal and other professional fees; - Initial staffing; - Up to six months rent; - Furniture; - Reasonable rehabilitation costs. **OMH service providers using funding source code 031 must also indicate the funding source index in the funding source code index field on DMH-3.**

DMH Code #	OMH Only Index	Description
031	B	**Community Residence - Children** (OMH Only)
031	C	**New York/New York** (OMH Only)
031	F	**2000 Capital Bed Plan** (OMH Only)
031	G	**New York/New York III PDG**
034	A	**ICM Adult Managers** - (OMH Only)
034	B	**ICM Children Managers** - (OMH Only)
034	C	**ICM Adult Service Dollars** - (OMH Only)
034	E	**ICM Children Service Dollars** - (OMH Only)
036		**Comprehensive Psychiatric Emergency Program** - (OMH). Article 28 General Hospitals are eligible for funding at the rate of 100% of approved net operating costs for providing complete crisis response system of crisis intervention, crisis outreach and crisis residence.
037		**Ongoing Integrated Supported Employment Services** – (OMH Only) - These funds are intended for ongoing job maintenance services including job coaching, employer consultation, and other relevant supports needed to assist an individual in maintaining a job placement.
037	A	**A Peer Support/Psych. Rehab.** – (OMH Only) – For 100% of net operating expenses incurred for approved new or expanded Peer Support and/or Rehabilitation programs.
037	P	**Personalized Recovery Oriented Services (PROS) -** (OMH Only)
038		**Mental Health Initiatives – OMH Member Item 100% 001 Funding**
038	A	**Farm Net – OMH Member Item 100% 001 Funding**
038	B	**Relief Resources – OMH Member Item 100% 001 Funding**
038	C	**Hospital Audiences – OMH Member Item 100% 001 Funding**
038	D	**Eating Disorders – OMH Member Item 100% 001 Funding**
038	E	**Conference of Local MH Directors – OMH Member Item 100% 001 Funding**
038	F	**Mental Health Association of Rockland County – OMH Member Item 100% 001 Funding**
038	G	**Mental Health Association of Orange County – OMH Member Item 100% 001 Funding**
038	H	**Occupations, Inc. – OMH Member Item 100% 001 Funding**
038	I	**NYU Child Study Center – OMH Member Item 100% 001 Funding**
038	L	**North Country Children's Mental Health – OMH Member Item 100% 001 Funding**
038	M	**NASW-NY Training and Education for Providers Dealing with Veterans – OMH Member Item 100% 001 Funding**
038	N	**Health Care Coverage for Direct Care workers – OMH Member Item 100% 001 Funding**
038	O	**Ohel Children & Family Services – OMH Member Item 100% 001 Funding**

DMH Code #	OMH Only Index	Description
039	A	**Legislative Special** – Assembly Items (OMH Only)
039	B	**Case Management** - (OMH Only)
039	C	**MICA** - (OMH Only)
039	D	**Legislative Special Contracts– Senate** (OMH Only) – 100%
039	E	**Legislative Special Contracts –** Re-appropriations (OMH Only) - 100%
039	F	**Therapeutic Nurseries** - (OMH Only)
039	G	**Adult Family Support** - (OMH Only)
039	H	**Compulsive Gambling** - (OMH Only)
039	J	**Forensics** - (OMH Only)
039	L	**Psychiatric Rehabilitation** - (OMH Only)
039	M	**Support Services to Consumers** - (OMH Only)
039	P	**Clinical Infrastructure – Adult** (OMH Only)
039	Q	**Innovative Psychiatric Rehab –** (OMH Only)
039	V	**Legislative Special – Governor (OMH Only) 100% State Funded**
039	Z	**Psychiatric Center Rent - Adult** (OMH Only) effective 1/1/96.
040		**Demonstration Grants** - (OMRDD) (Article 41, Section 35, Title E, Mental Hygiene Law). The Commissioners of DMH may develop plans for three or more time limited demonstration programs, the purpose of which is to test and evaluate new methods or arrangements for organizing, financing, staffing and providing services for the mentally disabled in order to determine the desirability of such methods or arrangements. The demonstration programs required to be developed include at least one single system program for comprehensive services for OMRDD clients to be provided by local governments. The local government units receive grants from the department not to exceed 75% of net operating costs.
041		**Federal Community Mental Health Services Block Grant Funds - Adult** - (OMH).
044		**Federal Community Mental Health Services Block Grant Funds – C+F** - (OMH).
046		**Children and Families Program Grants** - (OMH). For 100% of the net operating expenses incurred by local governments and voluntary providers in support of mental health programs for children and families (General and Special Revenue Funds).
046	A	**Clinical Infrastructure – Children and Families** – (OMH Only)
046	C	**Coordinated Children's Services Initiatives** - (OMH Only)
046	C & F	**Emergency Services** – (OMH Only)
046	K	**School Based Services Initiative** – (OMH only)
046	C & F	**Community Support Programs** - (OMH Only)
046	M	**Mott Haven System of Care** - (OMH Only)
046	N	**Child & Family Clinic Plus (State Aid)**
046	P	**Child & Family Telepsychiatry (State Aid)**

DMH Code #	OMH Only Index	Description
046	S	**School Support Services** - (OMH Only)
048	A	**Homeless MI (PATH) -** (OMH Only)
048	C	**New York/New York (PATH)** - (OMH Only)
049	A	**Federal PHP HUD Grants** - (OMH Only) Includes cases where funds flow through OMH only (federal years 1991 and 1992 only). Other cases use funding code 090.
049	B	**Federal HUD Shelter Plus Care** - (OMH Only) where funds flow through OMH only. Other cases, use code 062.
053		**Road to Recovery –** (OASAS Only)
057		**Supportive Work** - (OMRDD) Agencies are provided State Aid up to 100% of the net operating cost to enhance the continuum of day programming services in order to serve underserved persons over the age of 21, including the aging out and other individuals living at home.
058		**Family Support Services Funding** - (OMRDD). Agencies are provided State Aid up to 100% of the net operating costs related to the provision of family support services including but not limited to the following: respite, crisis intervention, family support training and counseling, home modification, transportation, recreation and special adaptive equipment.
059		**M.R. Crisis Intervention** - (OMRDD) 100%.
062		**Federal HUD Shelter Plus Care –** (OMH Only) 100% - Includes care where funds do not flow through OMH; non-OMH funds only.
072	A	**Adult Community Residence Operating** - (OMH Only)
072	B	**Children CR Operating** - (OMH Only)
072	C	**Single Room Occupancy** - (OMH Only) - Singe Room Occupancy (SRO) NY/NY I.
072	D	**RCCA Operating** - (OMH Only)
072	E	**NY/NY 2 Operating** - (OMH Only)
072	F	**2000 Capital Bed Plan – Operating**
072	G	**New York/New York III Operating**
072	T	**Community Residence Operating Costs for Former Transitional Care Individuals** - (OMH Only)
073	A	**Adult Community Residence Property** - (OMH Only)
073	B	**Children CR Property** - (OMH Only)
073	C	**New York/New York Property** - (OMH Only)
073	D	**RCCA Property** - (OMH Only)
073	E	**NY/NY 2 Property -** (OMH Only)
073	F	**2000 Capital Bed Plan Property**
073	G	**New York/New York III Property**
073	T	**Community Residence Property Costs for Former Transitional Care Individuals** - (OMH Only)

DMH Code #	OMH Only Index	Description
074		**Family Based Treatment** - (OMH). State Aid is provided to cover 100% of net cost.
076		**Residential Treatment Facilities** - (OMH) OMH will fund the State share of Medicaid cost of the residential care program incurred by children placed in these facilities.
078		**Independent Apartment/Supported Housing** - (OMH) 100% funding will be provided to not-for-profit agencies to locate and furnish housing for clients transitioning from CR programs to independent living. Funding will also be provided for client placement and follow up services.
078	G	**New York/New York III Supported Housing**
078	Z	**Single Room Occupancy (SRO)** (OMH Only) - housing related to the 99/00 housing add
080		**Homemaker Funds** - (OMRDD) Homemaker funds are provided through contractual arrangements with agencies, individuals and families to provide parent respite, home management, client training, and emergency assistance.
084	A	**Adule Flexible Funding** (OMH) - For counties that have elected to participate in flexible funding.
084	B	**Children and Families Flexible funding** - (OMH) -. For counties that have elected to participate in flexible funding.
084	C	**Flexible Funding** - (OMH Only) – 100% Local Share.
089		**Individual Support Services/HCBS Consolidated Supports and Services** - (OMRDD) 100%
090		**Non-Funded** - The non-funded category is used to balance the funding for programs that are outside the jurisdiction of DMH and/or program costs which are ineligible for state participation. Please note that gross expenses cannot have a negative balance.
091	A	**Federal SAMHSA (NYC Providers only)** – OMH Only.
091	C	**Federal Community Development Block Grant (Drop In Centers) (NYC Providers Only)** – OMH Only.
091	D	**Federal HOPWA (NYC Providers only) –** OMH Only.
091	E	**Emergency Shelter Grant (NYC Providers only)** – OMH Only.
096	A	**Community Based Family Care General** - (OMH) 100% State funded.
096	K	**Home and Community-Based Services Waiver** – General Fund (OMH Only).
104		**Supportive Case Management** - (OMH) 100% - Provides services necessary to maintain a client in the community. The program operates through approval letters with counties whose net deficits are funded at the rate of 100% State participation.
104	A	**SCM Service Dollars** - (OMH Only)

DMH Code #	OMH Only Index	Description
106		**State Operated ACT Team Service Dollars** - (OMH Only) 100% State Funded
111		**Federal Drug Free Schools & Communities Act - (OMH C&F Community Support Program)** - 100%
122		**Community Support Programs - Misc** (OMH Only). 100% State Funded**.**
122	L	**PROS Startup – Cash Advance (OMH Only) 100% State Funded**
122	P	**Prior Year Liability** (OMH Only) **–** Prior year liabilities reported in current year.
122	U	**PROS Start-Up Grants** (OMH Only)
122	W	**Western Care Coordination Project – Reallocated Savings** (OMH Only) – Off the top funding for the Western Care Coordination Project.
130		**Transitional Care -** (OMH Only 100%)
140	**Only valid with suffix**	**Health Care Reform Act (HCRA) -** (OMH Only 100%) – Special Revenue Tobacco Settlement Fund **OMH service providers using funding source code 140 must also indicate the funding source index in the funding source code index field on DMH-3.**
140	F	**HCRA Adult State Aid – Adult Supported Housing -** (OMH Only 100%)
140	G	**HCRA Children and Family – Home and Community – Based Waiver** - (OMH Only 100%)
140	H	**HCRA Children and Family State Aid – Children and Family Case Management** - (OMH Only 100%)
140	I	**HCRA Children and Family State Aid – Residential Treatment Facility (RTF) Transition Coordinator** - (OMH Only 100%)
140	J	**HCRA Children and Family State Aid – Family Support Services** - (OMH Only 100%)
140	K	**HCRA Children and Family State Aid – Family-Based Treatment** - (OMH Only 100%)
140	Y	**HCRA Adult State Aid – Adult Case Management/Other** - (OMH Only 100%)
152		**Developmental Disabilities Program Council** - (OMRDD Only 100%)
153		**Article 16 Clinic Programs** – (OMRDD Only)
154		**Traumatic Brain Injury** - (OMRDD Only 100%) - Agencies are provided State Aid up to 100% of the net operating costs related to the provision of services to individuals with Traumatic Brain Injury. These services include: information, referral, counseling, advocacy training, intake and linkage to other professionals through client specific discussion.
155		**Voluntary Preservation Project - formerly know as Voluntary Operated Maintenance Contract** - (OMRDD) 100% State Aided
162		**Geriatric Health Act**

DMH Code #	OMH Only Index	Description
164		**Suicide Prevention**
170	A	**Kendra's Assisted Outpatient (AOT) – Case Management/ICM** – (OMH Only -100%).
170	B	**Kendra's Assisted Outpatient (AOT) – Transitional Management (TM) –** (OMH Only -100%).
170	C	**Kendra's Medication Grant Program (MGP) Administration** – (OMH Only **-**100%).
170	D	**Kendra's Medication Grant Program (MGP**) – (OMH Only **-**100%).
170	E	**Kendra's Assisted Outpatient (AOT) – Case Management/SCM** – (OMH Only - 100%).
170	F	**Kendra's Assisted Outpatient (AOT) – Case Management/ACT Team** – (OMH Only **-** 100%).
170	K	**Kendra's Assisted Outpatient (AOT) – Case Management/Other** – (OMH Only **-** 100%).
170	L	**Kendra's Assisted Outpatient (AOT) – Case Management/ICM Service Dollars** – (OMH Only **-**100%).
170	M	**Kendra's Assisted Outpatient (AOT) – Case Management/SCM Service Dollars** – (OMH Only **-**100%).
170	N	**Kendra's Assisted Outpatient (AOT) – Case Management/ACT Service Dollars** – (OMH Only **-**100%).
170	P	**Kendra's Proxy – Advance Directives** – (OMH Only **-**100%).
188		**Health Care Enhancement – (OMRDD Only)**
189		**Epilepsy Services** – (OMRDD Only) – State Aid up to 100% of the net operating costs related to the provision of services to developmentally disabled individuals with epilepsy. Services include but are not limited to information and referral, counseling, education and support groups.
190		**Parole ACT-like Team** - (OMH Only) – 100%.
200		**Community Reinvestment Services Fund** - (OMH Only)
200	C	**Supported Housing Workforce RIV - (OMH Only) – 100%**
300		**Homeless Mentally Ill Fund** - (OMH Only)
400		**Commissioner's Performance Fund** - (OMH Only) – 100%.
503	A	**COLA - 2002/2003 3 Percent PATH COLA** (OMH Only) - 100%
505		**COLA – 2006/2007 2.8 Percent** (OMRDD Only) – 100%
530		**NYC Housing Resource Consortium** (OMRDD Only) -100%
550		**Adult Home Case Management** (OMH Only) – 100% - Case Management and Peer Specialist services at Adult Homes.
550	A	**Adult Home Case Management Service Dollars** (OMH Only) – 100%

Depreciation

The CFR does not include schedules detailing depreciation expense on assets such as buildings, equipment and vehicles. However, the service provider is required to maintain depreciation schedules that include the following minimum information:

- Description of Asset
- Date of Acquisition
- Cost at Acquisition
- State/Federal Funding for Items
- Salvage Value
- Depreciation Method
- Useful Life Used for Depreciation Purposes
- Annual Depreciation Amount
- Accumulated Depreciation

The following general rules shall apply for the calculation and reporting of depreciation expense:

- Assets having a unit cost of $1,000 or more **and** a useful life of 2 years or more must be depreciated. Conversely, items having a unit cost less than $1,000 **or** a useful life of less than 2 years may be expensed.

- Group purchases of like items should be treated as a single purchase. Group purchases of unlike items must be treated as if each item was purchased individually. Telephone systems and computer systems should be treated as a group purchase.

- For CFR purposes, the depreciable base is calculated by taking the total cost of the asset and subtracting the salvage value and the amount funded by State or Federal monies. (Note: Funds received via rates, prices, fees or net deficit funding should not be included in the calculation of State and Federal monies.) If 100% of the cost of an asset is funded specifically by State or Federal monies, the asset cannot be depreciated on the CFR. This will be a reconciling item between the CFR and the service provider's financial statements.

- Depreciation on assets which are shared among programs/sites or among program/sites and administration should be allocated on a reasonable basis. Documentation for the allocation basis must be available upon request. Refer to Appendices I and J.

- The "straight line method" of depreciation must be used for all classes of assets funded by the New York State Agencies. Use of the one month, six month, or full year convention is acceptable.

  When assets are shared by programs funded by more than one New York State Agency, the rules of majority funding shall dictate.

- The useful life of depreciable assets shall be the higher of the reported useful life or the useful life from the 2004 edition of the Estimated Useful Lives of Depreciable Hospital Assets. This document is available from:

  The publisher: Health Forum, Inc.
  1 North Franklin
  28th Floor
  Chicago, IL 60606

  The American Hospital Association
  840 Lake Shore Drive
  Chicago, IL 60611

The Estimated Useful Life Guidelines must be used in the calculation of depreciation expense unless the service provider can justify that an alternative useful life is more appropriate. Documentation to support the use of alternative useful lives must be available upon request.

Amortization

The CFR does not include schedules that calculate the amortization expense related to intangible assets, organizational expenses, leaseholds, leasehold improvements and mortgage expense. However, the service provider is required to maintain amortization schedules which include the following minimum information:

Description of Item
Beginning Date of Amortization
Length of Amortization
Costs to be Amortized
Accumulated Amortization
Current Year Amortization

The following general rules apply for the calculation and reporting of amortization expense:

- Organizational expenses are amortized over a period of 60 months, starting with the month the first participant is admitted to the program/site. Amortization of items which are shared among program/sites or among program/sites and administration should be allocated on a reasonable basis. Documentation for the allocation basis must be available upon request.

- Leasehold improvements are amortized over the term of the lease which includes any period for which the lease may be renewed, extended, or continued following either an option exercised by the service provider, or in the absence of an option, reasonable interpretation of past acts of the lessor and lessee pertaining to renewal, etc., unless the service provider establishes (omitting past acts) that it will probably not renew, extend, or continue the lease.

- Leasehold improvements which are the responsibility of the service provider under the terms of a lease are amortized over the useful life of the improvements or the remaining term of the lease, whichever is shorter.

- Mortgage expenses relate to the mortgages owed by the service provider and are amortized over the life of the mortgage. These expenses are **not allowed for OMRDD Residential Habilitation**.

Program Development Grants (PDGs)

Purpose

The purpose of Program Development Grant (PDG) funding is to assist residential service providers in commencing a new community residence program funded by OMH.

Approval And Distribution Process

PDG costs shall be reimbursed at 100% and may be advanced to the service provider according to their payment schedule. All PDG costs shall be documented by the provider as described in the submitted budget and shall be approved by the applicable field office. PDG's may run off-cycle.

Applicable Costs

Costs relating to starting a community residence program are appropriate PDG costs. Such costs include but are not limited to: initial recruitment, staffing, minor construction or remodeling costs, rent or other costs related to the use of space, purchases of automobiles or vans, furniture, some property costs, some architectural costs, office equipment and all client related furnishings.

Administrative costs of any kind are not allowable. Do not allocate any such costs to the PDG costs.

Only those costs which have been approved and budgeted as PDG costs may be included. This process should not be confused with the normal differences between cost reporting and claiming (i.e., items over $1,000 in cost must be capitalized on the cost report, but can be expensed in the current year on the claim if approved in the budget).

Reporting On The CFR

PDG costs should be reported as a separate program column. No units of service are associated with PDG costs. For OMH PDGs, enter “A0” as the program code index (for example, 6070 would become 6070 A0 for a Treatment/Congregate program receiving PDG funds).

Start-Ups - OMH

Purpose

The purpose of OMH Start-ups is to assist ongoing OMH service providers in purchasing equipment as a one time, non-recurring expense which, if included in the cost of the program, would exaggerate unit costs.

Approval And Distribution Process

OMH Start-up costs shall be reimbursed at 100% and may be advanced to the service provider according to their payment schedule. All OMH Start-up costs shall be documented by the service provider as described in the submitted budget and shall be approved by the applicable field office. OMH Start-ups may run off-cycle.

Applicable Costs

One time purchases or non-recurring costs are appropriate for OMH Start-ups. Such costs may include but are not limited to: major repairs due to emergency situations, purchases of vehicles, office equipment, consultant costs, which would have the effect of artificially increasing unit costs in an any one program year.

Administrative costs of any kind are not allowable. Do not allocate any such costs to OMH Start-up costs.

Only those costs which have been approved and budgeted as OMH Start-up costs may be included. This process should not be confused with the normal differences between cost reporting and claiming (i.e., items over $1,000 in cost must be capitalized on the cost report, but can be expensed in the current year on the claim if approved in the budget).

Reporting On The CFR

OMH Start-up costs should be reported by using “A0” as the program code index after the four digit program code (for example, 6050 would become 6050 A0 for a Supported Housing program receiving Start-up funds).

Start-Ups - OMRDD

Purpose

The purpose of OMRDD Start-up funding is to assist residential and Day service providers in commencing new residential and day programs funded by OMRDD.

Approval And Distribution Process

OMRDD Start-up costs shall be reimbursed at 100%, and 90% may be advanced to providers according to their payment schedule. All OMRDD Start-up costs shall be documented by the provider as described in the submitted budget and shall be approved by the applicable regional office. OMRDD Start-ups may run off-cycle.

Applicable Costs

Costs related to starting a residential or day program are appropriate OMRDD Start-up costs. Such costs include but are not limited to: initial recruitment, staffing, minor construction or remodeling costs, rent or other costs related to the use of space, purchases of furniture, some property costs, some architectural costs or office equipment.

Administrative costs of any kind are not allowable. Do not allocate any such costs to the OMRDD start-up costs.

Only those costs which have been approved and budgeted as OMRDD Start-up costs may be included.

Reporting On The CFR

OMRDD Start-up costs should be reported as a separate program column. No units of service are associated with OMRDD Start-up costs. OMRDD Start-up costs should be reported under the program type code 0190.

These guidelines are to be utilized by all OMH providers who operate Community Residences, Family Based Treatment Programs or other residential programs which have exempt income. Exempt income is income generated that exceeds the fixed amount defined in the fiscal model. (Refer to the residential exempt income policy and guidelines for specifics). The procedures for reporting these amounts on the Consolidated Fiscal Report are as follows:

Exempt Income (all sources except Medicaid):

For budget and claiming purposes, all income received (income from sources other than Medicaid) is to be reported as appropriate on the CFR. As noted in the CR Contract Policy and Guidelines, exempt income has been defined as being that amount by which actual income received exceeds the amount of the fiscal model income and is to be excluded from application against budgeted gross expenses in determining net deficit (and is retained by the service provider). For budget and claiming purposes, "exempt" income should be reported as "non-GAAP Adjustments to Revenue" on line 39 of Schedule DMH-2.2.

For budget and claiming purposes, exempt income which is spent in the current contract period will be reported on the appropriate revenue lines of Schedule DMH-2.1 and expenditures from exempt income will be reported in the appropriate expense category (lines 5 through 10 of Schedule DMH-2.1). If exempt income is partially spent in the current contract reporting period, that which is unspent must be reported on line 39 of Schedule DMH-2.2.

For CFR reporting on the core schedules (CFR-1 to CFR-6), exempt income should be considered a revenue, reported on the accrual basis of accounting and be reported on line 10 of Schedule CFR-2 and lines 69, 70, 71 or 74 of Schedule CFR-1.

Medicaid Exempt Income

For budget and claiming purposes, all Medicaid income is to be reported on the CFR, on line 17 of Schedule DMH-2.1. As noted in the CR Contract Policy and Guidelines, exempt income has been defined as being that amount by which actual income received exceeds the amount of the Fiscal Model with 50 percent of all Medicaid income in excess of the Fiscal Model expectation, to be applied against budgeted Gross Budget Expenses; and 50 percent of that amount to be excluded from application against budgeted Gross Budget Expenses in determining net deficit (and is retained by the service provider). To differentiate "exempt" income on the CFR, "exempt" income should be reported as "non-GAAP Adjustments to Revenue" on line 39 of Schedule DMH-2.2.

For budget and claiming purposes, exempt income which is spent in the current contract period will be reported on line 17 of Schedule DMH-2.1; and expenditures from exempt income will be reported in the appropriate expense category (lines 5 through 10 of Schedule DMH-2.1).

For CFR reporting on the core CFR schedules (CFR-1 to CFR-6), Medicaid Exempt Income must be considered a revenue, and be reported on the accrual basis of accounting on line 72 of Schedule CFR-1 and on line 10 of Schedule CFR-2.

Note: For budget and claiming purposes, exempt income not spent which is reported on line 39 of Schedule DMH-2.2 must be detailed by revenue source (SSI, Medicaid or other).

Select the position title and code that reflects functions performed by the individual(s) and enter the appropriate title and code number on Schedule CFR-4 and, if applicable, Schedule CFR-4A.

Note: Certain position titles are unique to individual New York State agencies. Be certain that the title used is acceptable for the New York State agency that provides your funding. OMH service providers should note that certain position title codes are only acceptable for certain types of OMH programs.

- **Agency administration staff must be assigned position title codes from 600 through 699.**
- **Local Governmental Unit (LGU program code 0890) staff must be assigned position title codes from 700 through 799.**
- **Program administration staff must be assigned position title codes from 500 through 599.**
- **Program/site staff must be assigned position title codes from 100 through 499.**

Below is an alphabetic listing of position titles to assist you in choosing appropriate titles. Following the alphabetic list is a numeric list of position title codes and definitions.

Position Title	Position Title Code
Accountant	606
Accountant/Bookkeeper	703
Administrative Assistant	612
Assessment/Intake (SED Only)	251
Assistant Executive Director	602
Assistant Mental Hygiene Director	702
Assistant Principal (SED Only)	515
Assistant Program Director	502
Case Manager	301
Clinical Coordinator (Does not apply to OMRDD)	342
Community Relations	610
Comptroller/Controller	603
Computer/Data/Statistical Specialist	609
Coordinator/Education Department Head (SED Only)	516
Counseling Aide/Assistant-Alcoholism and Substance Abuse (Does not apply to SED)	268
Counselor - Alcoholism and Substance Abuse (SED use Code 305)	267
Counselor - Rehabilitation (Master's Level)	305
Counselor (OMH CR Only)	203
Crisis Intervention Worker (SED Only)	243
CSE/CPSE Chairperson (SED Only)	511
Curriculum Coordinator/IEP Coordinator (SED Only)	237

Position Title	Position Title Code
Developmental Disabilities Specialist/Habilitation Specialist- QMRP - Clinical (OMRDD & SED Only)	309
Developmental Disabilities Specialist - QMRP - Direct Care (OMRDD Only) (SED use 309)	207
Dietician/Nutritionist (OMH, OMRDD & OASAS Only)	336
Director of Division	604
Emergency Medical Technician	312
Executive Director/Chief Executive Officer	601
Family Counselor/Therapist	344
Food Service Worker (OASAS & OMRDD use 336 for Dietician/Nutritionist)	101
Guidance Counselor (SED Only)	236
Housekeeping and Maintenance	102
Identification/Information Referral (OASAS Only)	346
Intake/Screening	343
Intensive Case Manager (OMH Only)	313
Intensive Case Manager/Coordinator (OMH Only)	314
Job Coach/Employment Specialist (OMH, OMRDD Only)	254
Manager (OMH CR Only)	204
Marketing (Agency Administration)	614
Marketing (Program Administration)	509
Mental Hygiene Director/Commissioner of Mental Hygiene	701
Mental Hygiene Worker (not for OMH CR) (Does not apply to SED)	201
Nurse - Licensed Practical	316
Nurse Practitioner/Nursing Supervisor	315
Nurse – Registered	317
Nurses Aide/Medical Aide	339
Office Worker (Agency Administration)	605
Office Worker (LGU Administration)	704
Office Worker (Program Administration)	505
Other Agency Administration Staff	690
Other Clinical Staff/Assistants	390
Other Direct Care Staff	290
Other LGU Administration Staff	790
Other Program Administration Staff	590
Other Support Staff	190
Paraprofessional - Non-Disabled (SED Only)	265
Paraprofessional - Social Services (SED Only)	213
Pharmacist	350
Physician's Assistant	319
Physician - M.D.	320
Prevention/Education (OASAS Only)	345
Principal of School (SED Only)	514
Production Staff	400

Position Title	Position Title Code
Program Director	501
Program Research/Evaluation	510
Psychiatrist	318
Psychologist (Licensed)	321
Psychologist (Master's Level)/Behavioral Specialist	322
Psychology Worker/Other Behavioral Worker	323
Residence Worker (Does not apply to SED)	202
RTF (Residential Treatment Facility) Transition Coordinator (OMH Only)	352
Security	105
Senior Counselor (OMH CR Only)	205
Service Coordinator Medicaid Service Coordination (OMRDD Only)	351
Social Worker, Certified (CSW)	324
Social Worker Master's Level (MSW)	325
Staff Training (Agency Administration)	620
Staff Training (Program Administration)	520
Staff Training (Program/site) (OMRDD and SED only)	347
Supervising Teacher (SED Only)	215
Supervisor (OMH CR Only)	206
Supervisor - Social Services (SED Only)	513
Teacher Aide	228
Teacher Assistant	232
Teacher Aide/Assistant – Substitute	230
Teacher - Coverage/Floating (SED Only)	227
Teacher - Deaf (SED Only)	261
Teacher - Deaf/Blindness (SED Only)	263
Teacher - Hard of Hearing (SED Only)	262
Teacher - Non-Disabled (SED Only)	260
Teacher – Other	222
Teacher - Physical Education	220
Teacher - Special Education	218
Teacher – Speech Certified (SED Only)	225
Teacher - Substitute (SED Only)	224
Teacher - Vocational/Occupational Education (SED Only)	221
Therapist - Activity/Creative Arts	332
Therapist – Occupational	333
Therapist – Physical	334
Therapist – Recreation	330
Therapist – Speech	335
Therapy Assistant/Activity Assistant	337
Transportation Worker	104
Utilization Review/Quality Assurance (Agency Administration)	621
Utilization Review/Quality Assurance (Program Administration)	521
Utilization Review/Quality Assurance (Program/site) (OMRDD Only)	349

Note: Certain job titles are unique to individual New York State agencies. Be certain that the title used is acceptable for the New York State agency that provides your funding. OMH service providers should note that position titles are only acceptable for certain types of OMH programs.

Below is a numeric list of position title codes:

Code Number	Position Title/ Job Title(S)	Definitions
Support Staff		
101	Food Service Worker	All individuals associated with the supervision, preparation or production of food. Job titles may include: Baker, Butcher, Canteen Worker, Chef, Cook, Assistant Cook, Dietician, Dining Room Worker, Dishwasher, Food Manager, Assistant Food Manager, Kitchen Worker, Wait Staff. **OASAS, OMH & OMRDD:** Use Code 336 for Dietician/Nutritionist
102	Housekeeping and Maintenance	All individuals associated with the maintenance, cleaning and repair of the physical environment of a building. Job titles may include: Boiler Engineer, Carpenter, Chief Engineer, Cleaner, Custodian, Domestic Worker, Electrician, Engineer, Facility Related Workers, Foreman, Groundskeeper, Handyman, Housekeeper, Housekeeping Supervisor, Janitor, Maintenance Engineer, Maintenance Supervisor, Mason, Matron, Mechanic, Painter, Plumber, Porter, Supervisor of Physical Plant Operations.
104	Transportation Worker	All individuals engaged in maintaining the vehicles for or providing or supervising the transportation of program participants. Job titles may include: Attendant, Bus Monitor, Driver, Escort, Transportation Aide, Transportation Coordinator, Transportation Supervisor, Transportation Worker.
105	Security	All individuals engaged in providing or supervising the security of a building. Job titles may include: Caretaker, Security Officer, Watchman.
190	Other Support Staff	All individuals engaged in providing or supervising other support services not listed in the 100 series. Job titles may include: Audio-Visual, Receiving Clerk, General Labor, etc.
Direct Care Staff		

Code Number	Position Title/ Job Title(S)	Definitions
201	Mental Hygiene Worker (not for OMH CR) (Does not apply to SED)	All individuals engaged in providing non-discipline specific services which involve the training of ADL skills; provide personal care to program participants; promote habilitation and/or rehabilitation. Job titles may include Habilitation Specialist, Residence Counselor, House Parents, ADL Specialist, Instructor and Trainer, Residence Staff, Relief Staff, House Apartment Worker.
202	Residence Worker (Does not apply to SED)	All individuals engaged in supervising non-discipline specific services which involve the training of ADL skills; provide personal care to program participants; promote habilitation and/or rehabilitation. Individuals in this position title do not perform any other administrative duties beyond the direct supervision of Direct Care staff. If other administrative functions are performed, allocate that portion associated with these functions using position code 501 or 502. Job titles may include Residence Director, Residence Manager, Hostel Manager, Residence Coordinator.
203	Counselor (OMH CR Only)	All individuals who perform this role as defined in the OMH Community Residence Program Model.
204	Manager (OMH CR Only)	All individuals who perform this role as defined in the OMH Community Residence Program Model.
205	Senior Counselor (OMH CR Only)	All individuals who perform this role as defined in the OMH Community Residence Program Mode.
206	Supervisor (OMH CR Only)	All individuals who perform this role as defined in the OMH Community Residence Program Model.
207	Developmental Disabilities Specialist QMRP – Direct Care (OMRDD Only) (SED Use Code 309)	All individuals not included within another listed title with at least a Bachelor's degree in an appropriate field or one year of experience working with the developmentally disabled engaged in providing or supervising services to program participants and their families. Job titles may include: Habilitation Specialist, Residence Counselor.
213	Paraprofessional - Social Services (SED Only)	All individuals under the immediate supervision and direction of a supervisor or caseworker and performs various support activities of case work services. Job title may include: Case Aide, Group Worker, Intern-Social Services, Family Advocate/Therapist.

Code Number	Position Title/ Job Title(S)	Definitions
215	Supervising Teacher (SED Only)	Provides for direct supervision of teachers. Job titles may include: Head Teacher, Assistant Teacher – Supervisor.
218	Teacher - Special Education	A certified teacher who provides specialized instruction to students with disabilities.
220	Teacher – Physical Education	Self-explanatory.
221	Teacher – Vocational/Occupational Education (SED Only)	Self-explanatory.
222	Teacher – Other	Self-explanatory. Job titles may include teachers of: Art, Music, Dance, Drama, Computer, Home Economics, Industrial Arts, Keyboarding; Learning Disability Specialist, Reading Specialist, Resource Room Teacher or teachers certified as Teacher of the Blind and Partially Sighted, Teacher of the Visually Impaired.
224	Teacher – Substitute (SED Only)	Self-explanatory. This is not a permanent position but is maintained on payroll records.
225	Teacher – Speech Certified (SED Only)	Certified as Teacher of Speech and Hearing Handicapped or Teacher of Deaf and Hearing Impaired.
227	Teacher - Coverage/Floating (SED Only)	An individual who covers sick days on a regular basis as a permanent position or as an extra teacher. The position is maintained on payroll records.
228	Teacher Aide	Assists teachers in non-teaching duties such as managing records, materials and equipment, attending to the physical needs of students and supervising students.
230	Teacher Aide/Assistant – Substitute	An individual who covers sick days of teacher aide or teacher assistant personnel. This is not a permanent position but it is maintained on payroll records.
232	Teacher Assistant	An individual who assists teachers in duties such as working with individual students or groups of students on special instructional projects, providing teachers with information about students, assisting students in the use of instructional resources, assisting teachers in the development of instructional materials and assisting in instructional programs.

Code Number	Position Title/ Job Title(S)	Definitions
236	Guidance Counselor (SED Only)	Self-explanatory. Job titles may include: School Counselor, Vocational Counselor.
237	Curriculum Coordinator/IEP Coordinator (SED Only)	Self-explanatory.
243	Crisis Intervention Worker (SED Only)	Self-explanatory. Also includes Child Guidance Worker.
254	Job Coach/Employment Specialist (OMH, OMRDD Only)	An individual who is responsible for the provision of intensive or extended training related services and supports necessary to obtain employment in the community or for the development of employment opportunities with business and industry.
260	Teacher – Non-Disabled (SED Only)	Self-explanatory. (For use in Preschool Integrated Programs).
261	Teacher – Deaf (SED Only)	Self-explanatory.
262	Teacher – Hard of Hearing (SED Only)	Self-explanatory.
263	Teacher - Deaf/Blindness (SED Only)	Self-explanatory.
265	Paraprofessional - Non-Disabled (SED Only)	Self-explanatory. (For use in Preschool Integrated Programs). Includes Non-Disabled Teacher Aides and Assistants.
267	Counselor – Alcoholism and Substance Abuse (CASAC) (SED Use Code 305)	An individual credentialed by the New York State Office of Alcoholism and Substance Abuse Services.
268	Counseling Aide/Assistant - Alcoholism and Substance Abuse (Does not apply to SED)	An individual functioning as defined for Alcoholism and Substance Abuse Counselor under supervision but who does not have a credential issued by the Office of Alcoholism and Substance Abuse Services.
290	Other Direct Care Staff	Anyone not listed in the 200 series engaged in providing direct care services.
Clinical Staff		
301	Case Manager	Supervises the implementation of each individualized program, monitors services received, records progress and initiates required periodic reviews. Job title may include: Client Coordinator.

Code Number	Position Title/ Job Title(S)	Definitions
305	Counselor - Rehabilitation	All individuals who have a degree in rehabilitative counseling from a program approved by the State Education Department or with current certification by the Commission on Rehabilitation Counselor Certification.
309	Developmental Disabilities Specialist/Habilitation Specialist QMRP – Clinical (OMRDD & SED Only)	All individuals not included in otherwise listed titles with at least a Bachelor's degree in an appropriate field from an accredited program and specialized training or one year experience working with the developmentally disabled engaged in providing or supervising services to program participants and their families.
312	Emergency Medical Technician	An individual certified by the New York State Department of Health for a period of three years as being qualified in all phases of medical emergency technology including, but not limited to communications, first aid, equipment maintenance, emergency room techniques and procedures, patient handling and positioning, and knowledge of procedures and equipment used for obstetrics, respiratory and cardiac emergencies who has passed an examination in the regular and advanced American Red Cross first aid courses and other training as required by the Commissioner of Health.
313	Intensive Case Manager (OMH Only)	An individual who will engage clients through outreach, monitor and coordinate evaluations and assessments to identify client needs, coordinate and participate with clients in the development of a service plan, provide coordination and assistance in crisis intervention and stabilization, assist in achieving service plan objectives, independence and productivity through "on the street" support, training and assistance in use of personal and community resources, assist in developing community supports and networks and advocate for changes in the system.
314	Intensive Case Manager/Coordinator (OMH Only)	In addition to the duties of the Intensive Case Manager, the Coordinator is responsible for supervising the Intensive Case Manager, monitoring the service dollars plan and expenditures, and negotiating with provider agencies for the care of clients.

Code Number	Position Title/ Job Title(S)	Definitions
315	Nurse Practitioner/Nursing Supervisor	Licensed professional nurse who has advanced certification through the American Nurses Association in a clinical specialty area or who has completed a program registered by SED and received a certification of completion in a clinical specialty area relevant to the treatment of the disability being treated.
316	Nurse – Licensed Practical	Licensed as a practical nurse by SED. Under the supervision of a supervisory nurse or registered nurse, the LPN administers prescribed medication and treatment to persons and assists in carrying out the planned health care program and maintenance of health records.
317	Nurse – Registered	Licensed as a registered nurse by SED. Under the supervision of a physician or a supervising nurse, this person provides direct treatment and dispenses prescribed medication.
318	Psychiatrist	Licensed as a physician by SED and certified or eligible to be certified by the American Board of Psychiatry and Neurology. Responsible for providing psychiatric services, including diagnosis and prognosis for purposes of determining appropriate placement services. Also counsels other appropriate staff regarding individual therapy.
319	Physician's Assistant	Licensed and registered as such by SED and whose practice is in conformity with Section 3701 of the Public Health Law.
320	Physician - M.D.	Licensed by SED as a physician in general practice or specialized medicine.
321	Psychologist (Licensed)	Licensed as a psychologist by SED. Performs duties associated with the diagnosis and treatment of persons, including administering and interpreting projective and other psychological tests.
322	Psychologist (Master's Level)/ Behavioral Specialist	Individuals who have at least a Master's degree in psychology but are not licensed, and who provide routine psychological services under the supervision of a licensed psychologist.
323	Psychology Worker/Other Behavioral Worker	Individuals with less than a Master's degree in psychology, who provide routine psychological services under the supervision of a licensed psychologist.
324	Social Worker, Certified (CSW)	Individuals who are certified in this discipline by SED.

Code Number	Position Title/ Job Title(S)	Definitions
325	Social Worker - Master's Level (MSW)	Individuals with a Master's degree in social work who are not certified but who are engaged in the provision of routine social work.
330	Therapist – Recreation	Individuals who have a Bachelor's or Master's degree in therapeutic recreation from a program approved by SED or a registration in this discipline by the National Therapeutic Recreation Society.
332	Therapist - Activity/Creative Arts	Provide, supervise or direct professional activity or creative arts therapy services (music, art, etc.) and hold at least a Bachelor's degree and, where applicable, are certified by SED or a recognized national professional organization.
333	Therapist – Occupational	Individuals licensed in this discipline by SED.
334	Therapist – Physical	Individuals licensed in this discipline by SED.
335	Therapist – Speech	Individuals licensed in this discipline by SED.
336	Dietician/Nutritionist (OASAS, OMH & OMRDD Only)	An individual responsible for the planning of nutritionally balanced meals or overseeing special diets as prescribed by a physician.
337	Therapy Assistant/Activity Assistant	An individual performing functions defined as teachers or therapists not otherwise coded.
339	Nurse's Aide/Medical Aide	Under the supervision of the professional staff, assists in performing routine duties.
342	Clinical Coordinator (Does not apply to OMRDD)	Responsible for overseeing clinical aspects of the program, including staff supervision and case review.
343	Intake/Screening	An individual who is responsible for initial assessment, screening and referral of persons presented for admission
344	Family Counselor/Therapist	An individual responsible for providing assessment or counseling services to more than one member of the family in the same session.
345	Prevention/Education (OASAS Only)	An individual providing alcohol information education, training and program technical assistance to the community, schools, parents, young people, special target populations and other health and human service prevention and treatment providers.
346	Identification/Information Referral (OASAS Only)	An individual who identifies persons with problems that may be associated with alcohol use, provide screening and, when needed, information to accept a referral for assessment of appropriate treatment services.

Code Number	Position Title/ Job Title(S)	Definitions
347	Staff Training (OMRDD and SED Only)	An individual responsible for training of program participant care staff in the areas of counseling, record keeping, case management, etc.
349	Utilization Review/ Quality Assurance (OMRDD Only)	An individual responsible for monitoring adequacy and/or appropriateness of program participant services and for compliance with all applicable federal, state and local laws, regulations and policies.
350	Pharmacist	Licensed by SED and responsible for dispensing medications.
351	Service Coordinator Medicaid Service Coordination (OMRDD Only)	An individual who provides MSC services in accordance with participant's Service Coordination Agreement and Individualized Service Plan (ISP). MSC service coordinators must meet the qualifications identified in the Medicaid Service Coordination Vendor Manual.
352	Residential Treatment Facility (RTF) Transition Coordinator (OMH Only)	An individual responsible for providing case management services for a child within the RTF; linking the child to local treatment and support at the time of discharge from the RTF; and providing time limited support to the child and family following discharge from the RTF to ensure a successful transition to a community setting.
390	Other Clinical Staff/Assistants	All individuals engaged in providing, supervising or specifically directing clinical services who are not included in the 300 series. Includes Dentistry, Radiology, Lab, Central Medical Supply.
Production Staff		
400	Production Staff	An individual engaged in providing, supervising or specifically directing production services including, but not limited to such titles as Production Manager, Workshop Supervisor, Warehouse Worker, Production Worker, Floor Supervisor, Contract Procurement Specialist, etc. Specify the title on Schedule CFR-4 and use this code number.
Program Administration Staff		
501	Program or Site Director	An individual responsible for the overall direct administration of: 1) a specific program type that operates at more than one site; or 2) multiple program types at a single site; or 3) a specific program type at a single site.

Code Number	Position Title/ Job Title(S)	Definitions
502	Assistant Program or Assistant Site Director	Assists either the Program Director or the Site Director in the direct administration of a specific program type. Job title may include: Assistant Education Director.
505	Office Worker	Responsible for record-keeping, billing, correspondence and general office duties.
509	Marketing	An individual responsible for promoting the program's services for the primary purpose of increasing facility utilization.
510	Program Research/Evaluation	Responsible for conducting ongoing evaluation or research.
511	CSE/CPSE Chairperson (SED Only)	The individual that heads a multidisciplinary team that coordinates evaluations and recommends programs and services for school age or preschool students with disabilities.
513	Supervisor – Social Services (SED Only)	Staff who directly supervise or assist in the supervision of the provision of Clinical Services, Social Services, or Educational Related Services. May also include Supervising Teacher, Head Teacher.
514	Principal of School (SED Only)	Self-explanatory.
515	Assistant Principal (SED Only)	Self-explanatory.
516	Coordinator/Dept. Head (SED Only)	Self-explanatory. Job titles may include: Program Specialist, Director of Program Development, Program Coordinator/Manager.
520	Staff Training	An individual responsible for the training of program staff. (**OMRDD and SED**: Use Code 347).
521	Utilization Review/Quality Assurance	An individual responsible for monitoring the adequacy and/or appropriateness of program participant services and for compliance with all applicable federal, state and local laws, regulations and policies. (**OMRDD**: Use Code 349)
590	Other Program Administration Staff	Any program administration staff not listed in the 500 series. Job title may include: Supported Employment Coordinator.
Agency Administration Staff		

Code Number	Position Title/ Job Title(S)	Definitions
601	Executive Director/Chief Executive Officer	Responsible for the overall administration of the agency. This position is usually appointed by and is under the general direction of the governing board of the agency.
602	Assistant Executive Director	Assists the Executive Director in the overall administration of the agency and acts on their behalf when necessary.
603	Comptroller/Controller	Responsible for overall fiscal management of the agency. Also includes Business Official, Director of Finance.
604	Director of Division	Responsible for overseeing a major segment of functions for the agency. Also includes Director of Admissions, Director of Purchasing, Director of Human Services, Director of Personnel, Director of Public Relations, Director of Data Processing
605	Office Worker	Responsible for agency-wide record-keeping, billing, correspondence and general office duties.
606	Accountant	Responsible for the establishment and maintenance of the agency's systematic fiscal transactions and preparation of financial statements for the agency. This position title does not include consultants.
609	Computer/Data/Statistical Specialist	Responsible for developing computer applications and/or provision of computer support.
610	Community Relations	Responsible for activities designed to present a positive public image of the agency/program.
612	Administrative Assistant	This position functions primarily as assistant to agency management in the performance of such activities as communications with internal or external parties, preparation of written work, liaison work, etc.
614	Marketing	An individual responsible for promoting the agency's services.
620	Staff Training	An individual responsible for training of agency staff.
621	Utilization Review/Quality Assurance	An individual responsible for monitoring the adequacy and/or appropriateness of the agency's services and for compliance with all applicable federal, state and local laws, regulations and policies
690	Other Agency Administration Staff	Includes all miscellaneous administration titles not included in the 600 series.
Local Governmental Unit Administration		

Code Number	Position Title/ Job Title(S)	Definitions
701	Mental Hygiene Director/ Commissioner of Mental Hygiene	The individual responsible for the overall direction of the mental hygiene activities/programs of the county
702	Assistant Mental Hygiene Director	The individual who assists the Director/Commissioner of Mental Hygiene and acts in his/her behalf when absent in the overall direction of mental hygiene activity of the county.
703	Accountant/ Bookkeeper	The individual responsible for recording and maintaining mental hygiene fiscal transactions of the county.
704	Office Worker	The individual performing as secretary/clerk and/or billing mental hygiene programs of the county.
790	Other LGU Administration Staff	Any LGU administration staff that are not listed in the 700 series.

Administering Agency	Code	CFDA
Federal:		
Employment and Training Administration	ETA	17.219, 17.232, 17.238, 17.243
Employment and Training Administration	ETAWIN	13.646
Health and Human Services	HHS	
Community Mental Health Services (CMHS) Block Grant		93.958
PATH Grant		93.150
Medicaid		93.775
Medicaid Salary Sharing		93.778
Office of Human Development Services	OHDSDD	13.630
Office of Human Development Services	OHDS	13.644
Department of Justice	DOJ	16.452, 16.541, 16.560, 16.561, 16.601, 16.602
National Institute on Mental Health	NIMH	13.242, 13.244, 13.281, 13.282, 13.295
National Institute on Alcohol Abuse and Alcoholism	NIAAA	13.252, 13.271, 13.272, 13.273, 13.274, 13.891, 13.898, 131.899
National Institute on Drug Abuse	NIDA	13.275, 13.277, 13.278
National Highway Traffic Safety Administration	NHTSA	20.600
Office of Education	OE	13.427
Office of Education	OE1	13.446, 13.449
Office of Education	OE2	13.451, 13.489, 13.560
Office of Education	OE3	13.416, 13.482, 13.499
All Other Federal Education Programs	OE4	
U.S. Veteran's Administration	VA	
Old Age Survivors Disability Insurance	OASDI	
Federal Emergency Management Agency	FEMA	
All Other Federal Grants	OTHFED	
State:		
Office of Alcoholism and Substance Abuse Services (for Substance Abuse Services)	OASAS - SAS	

Not included in this manual.

Please see the Consolidated Fiscal Reporting and Claiming Manual.

Mental Hygiene Law 41-18 (Section b) Local Services Plan states "Local governments shall be granted State Aid in accordance with the provisions of this subdivision, for approved net operating costs pursuant to an approved local services plan at the rate of fifty percent of the amount incurred during the local fiscal year by such local governments and by voluntary agencies pursuant to contract with such local governments; provided, however, that a local government having a population of less than two hundred thousand shall be granted State Aid at the rate of seventy-five percent for the first one hundred thousand dollars of its approved net operating costs." The following is the distribution for these counties:

County Name	Population	OASAS	OMH	OMRDD	Total
Allegany	50,470	$2,290	$6,057	$16,653	$25,000
Cattaraugus	84,234	343	7,962	16,695	25,000
Cayuga	82,313	0	5,600	19,400	25,000
Chautauqua	141,895	0	25,000	0	25,000
Chemung	95,195	3,750	6,500	14,750	25,000
Chenango	51,768	3,000	12,000	10,000	25,000
Clinton	85,969	1,600	11,900	11,500	25,000
Columbia	62,982	0	12,500	12,500	25,000
Cortland	48,963	2,300	9,400	13,300	25,000
Delaware	47,225	1,900	4,400	18,700	25,000
Essex	37,152	10,000	10,000	5,000	25,000
Franklin	46,540	0	25,000	0	25,000
Fulton	54,191	4,000	18,000	3,000	25,000
Genesee	60,060	3,000	16,000	6,000	25,000
Greene	44,739	0	11,000	14,000	25,000
Hamilton	5,179	6,902	14,025	4,073	25,000
Herkimer	65,797	3,300	20,500	1,200	25,000
Jefferson	110,943	5,000	18,000	2,000	25,000
Lewis	26,796	0	12,500	12,500	25,000
Livingston	62,373	0	25,000	0	25,000
Madison	69,120	5,000	10,000	10,000	25,000
Montgomery	51,981	3,000	22,000	0	25,000
Ontario	95,101	1,300	11,600	12,100	25,000
Orleans	41,846	5,000	15,000	5,000	25,000
Oswego	121,771	5,000	15,000	5,000	25,000
Otsego	60,517	5,000	10,000	10,000	25,000
Putnam	83,941	3,896	14,400	6,704	25,000
Schenectady	149,285	12,500	12,500	0	25,000
Schoharie	31,859	4,729	3,973	16,298	25,000
Schuyler	18,662	2,000	11,500	11,500	25,000
Seneca	33,683	1,500	4,750	18,750	25,000
St. Lawrence	111,974	12,500	12,500	0	25,000

County Name	Population	OASAS	OMH	OMRDD	Total
Steuben	99,088	6,645	6,968	11,387	25,000
Sullivan	69,277	1,900	4,900	18,200	25,000
Tioga	52,337	3,000	12,700	9,300	25,000
Tompkins	94,097	8,333	8,334	8,333	25,000
Ulster	165,304	2,300	14,800	7,900	25,000
Wayne	89,123	1,284	8,948	14,768	25,000
Wyoming	42,507	14,300	10,700	0	25,000
Yates	22,810	0	8,800	16,200	25,000
Total		**$149,072**	**$510,717**	**$365,211**	**$1,025,000**

These guidelines are to be utilized by all counties who receive Federal Medicaid Administrative Salary Sharing (Salary Sharing) revenue from OMH. Through participation in the Salary Sharing program, counties can be reimbursed for part of the local governmental cost of (a) county staff time associated with the administration of the mental health portion of the Medicaid program and/or (b) subcontractors who administer the mental health portion of the Medicaid program. The local governmental costs associated with the administration of the mental health portion of the Medicaid program are hereafter referred to as *Local Medicaid Administration.*

Note: Counties are liable for all Salary Sharing claims subject to Federal and state audit, and are solely responsible for ensuring that their Salary Sharing claims for Local Medicaid Administration are in compliance with applicable Federal Regulations. Regarding Salary Sharing in general, please refer to Title 42 (Public Health) of the Code of Federal Regulations (CFR), Part 433 (State Fiscal Administration); regarding subcontracts specifically, please refer to Title 42, CFR Part 434.6 (General Requirements For All Contracts and Subcontracts). All documentation of contract specifications must be kept by the County.

Purposes Toward Which Local Medicaid Administration Salary Sharing Revenue Can Be Applied

Local Medicaid Administration Salary Sharing revenue is to be used for county/NYCDMH operated mental health services only, and must be applied toward either:

- mental health LGU Administration costs (OMH program 0890 – LGU Administration); or
- any other exclusively-OMH-funded, county/NYCDMH operated mental health program costs (i.e., programs that receive funding through OMH funding sources such as Local Assistance and CSS, and this includes non-Medicaidable programs).

Procedure To Be Followed If Local Medicaid Administration Salary Sharing Revenue Is To Be Utilized For LGU Program Expansion

If, during the course of the year, the Local Medicaid Administration Salary Sharing revenue received from OMH is used specifically for OMH LGU administration program expansion (OMH program 0890), then the expenditures related to LGU program expansion must be assigned entirely to OMH, and therefore, the total amount of LGU administration expenses split among the participating disabilities is to be reduced by an amount equal to the expenditures related to OMH LGU Administration program expansion. After the LGU Administration expenses have been reduced, calculate the shares assigned to each disability based on the “Department of Mental Health County Administration Percentage Splits for the Year 1988". The LGU Administration share assigned to OMH (based on the “splits”) is then to be increased by the expenditures made for OMH LGU administration program expansion.

Other Reporting Provisions

If a line utilized for the purpose of reporting Salary Sharing revenue contains revenues other than Salary Sharing revenue, then a subschedule that details all of the sources of revenue reported on this line needs to be attached to the CCR.

Procedures Specifically Regarding The Approved CFR Software

Providers who: (1) utilize approved CFR software for the purpose of completing year-end claiming schedules, and; (2) report all or some portion of the Salary Sharing revenue received from OMH in the LGU Administration program (under OMH program 0890) must ensure that the Salary Sharing revenue is *not* divided among the participating disabilities based on the "Department of Mental Health County Administration Percentage Splits for the Year 1988", but is applied entirely as an offset to the share assigned to OMH (you will need to directly enter this revenue information at the data entry screens for the schedules detailed above.)

As a reminder, Chapter 166 of the Laws of 1991 added Article XI-B to the State Finance Law which promoted prompt contracting with not-for-profit (NFP) organizations and mandated by law prompt contract timeframes. If the NFP does not receive its first contract payment on time (i.e., in strict accordance with the contract payment schedule), the Department of Mental Hygiene will incur an interest penalty that will be payable from the State Operations appropriation. Since an annual report must be provided to the Governor's Office of Management and Productivity and the State Legislature regarding compliance with the timeframes for processing contracts and interest liabilities incurred, it is especially important that all NFP's receive their first contract payment on time.

A recent amendment to the Prompt Contract Law (PCL) adds some limited flexibility to the original provisions set forth in Article XI-B of the State Finance Law, and provides for a smoother flow of program services and payments. The revisions should enable State agencies to process contracts and payments for NFP's in a timely manner without incurring unreasonable interest liabilities. The revisions provide more reasonable timeframes for processing local grant awards (i.e., Legislative Member Items) and federally funded contracts; allow State agencies and NFP's to agree to waive interest payments in certain circumstances; eliminate interest penalties for contracts executed and funded in whole or in part for services rendered in a prior fiscal year; and limit the amount of time any one agency may suspend the law's timeframe to 4 ½ months in any State fiscal year.

The Division of the Budget has issued Budget Bulletin H-1016 which explains the revisions to the Prompt Contracting law. The key provisions of the budget bulletin are summarized below.

1. *Waiving Interest* - A State agency is permitted to process a contract with a NFP agency with a retroactive start date without being interest liable if the NFP agrees to waive interest.

   Example: Funds for Member Items are appropriated April 1 but the recipient NFP agency is not identified until four months later. In the meantime, through their own choice, the NFP began providing services on April 1. The new provision of the law permits the State agency to process a contract with a retroactive start date of April 1 without incurring interest, but only after the NFP signs a waiver that removes the State agency from being interest eligible since it would otherwise appear that the State agency was four months later in processing the contract.

2. *Suspending Prompt Contracting* - Prompt contract timeframes may be suspended for up to 4 months if a State agency, OSC, the Division of the Budget, or the Attorney General determines that extenuating circumstances exist which prevent the State agency from complying with the PCL timeframes. State agencies are required to notify the NFP of the suspension in writing, and submit a copy of the notification to OSC, the chairman of the Assembly Ways and Means Committee, and chairman of the Senate Finance Committee. The notification must specify the length of the suspension.

   Example: A statewide Deficit Reduction Plan ("DRP") is issued, and because of the chaos usually associated with it, a "time out" from the prompt contract timeframes for

processing contracts is called by the State agency. A written notice suspending the timeframes would be issued to the NFP. If such a notification is not issued, the State agency could be interest liable.

3. *Federally Funded Programs* - The new provision delays interest liabilities for federally funded contracts until four months after the State agency receives its federal funds, or after the contract's first payment due date, whichever is later.

   Example: OMH could delay processing its CMHS Block Grant funded contracts until it has received its Notice of Block Grant Award from the federal government, and then take up to four months to process the contracts. However, OMH has been processing contracts to OSC and having them pre-approved ("executory"). This ensures that the contracts are processed within the prompt contract timeframes.

4. *Timeframes for Local Grant Award* - The timeframes for processing Member Item contracts begins on the date DOB informs the State agency with lists identifying the recipients of such contracts. The State agency then has four months from the DOB identification to process the contract to OSC, and as required by the current law, the AG and OSC have one month to complete the approval process, for a total timeframe of five months from identification. Without this new provisions, State agencies would have incurred interest liabilities because by the time the Member Items are identified, the timeframes for processing the contract have already expired.

5. *Contracts Supporting Prior Year Services* - Interest liabilities have been eliminated where State agencies execute contracts that are funded entirely or partially with current year appropriations to pay for services rendered in a previous fiscal year.

Finally, as a reminder, if the DMH agency determines that a significant and substantive difference exists between itself and the NFP in the negotiation of a contract or renewal contract, or if the DMH determines that the NFP is not negotiating in good faith, then the DMH may suspend the written directive and any subsequent interest payments or subsequent advance payments required to be provided. Upon such suspension, the DMH is required to provide the affected NFP with written notification of such determination and the reasons (see Prompt Contracting Law, Section 179-W[3]).

This appendix lists certain items of expense that are considered non-allowable. Where this manual and/or state codes, rules and regulations are silent, DMH will defer to the guidelines published in the Federal Health Insurance Manual, commonly referred to as HIM-15. SED providers should refer to the SED Reimbursable Cost Manual for specific items that are not allowable for SED programs. OMRDD providers should also refer to Appendix EE for Reimbursement Principles.

If any of the following expenses have been included on Schedules CFR-1 through CFR-5 and DMH-1 through DMH-3, they should also be included on the line for Adjustments/Non-allowable costs. Examples include but are not limited to the following:

1. Bad debts resulting from uncollectible accounts receivable and related costs.

2. Costs that are not properly related to program/site participant care or treatment and which principally afford diversion, entertainment, or amusement to owners, operators or employees.

3. Costs incurred by a service provider as a result of making a monetary contribution to another individual or organization (for example, political contributions, charitable contributions, etc.).

4. Costs related to interest expense for programs receiving Aid to Localities funding that are in excess of an approved rate, fee, contract or funded amount. This also includes expenses associated with the cost of borrowing (however represented) and costs of financing and refinancing operations and associated expenses except where specific authority exists and prior approval has been obtained from the appropriate DMH office. Interest paid to a related individual or organization is not allowable unless a provider is owned and operated by members of religious order and borrows from the Mother House or Governing Body of the religious order.

5. Costs resulting from violations of, or failure to comply with Federal, State and Local government laws, rules and regulations, including fines, parking tickets, or the costs of insurance policies obtained solely to insure against such penalty.

6. Dues or portions of dues paid to any professional association or parent agency whose primary function is of a political or lobbying nature and whose intent is to influence legislation or appropriation actions pending before Local, State or Federal bodies.

7. Cost increases created by the lease, sale or purchase of a program/site physical plant which has not received the prior approval of the appropriate Department of Mental Hygiene office.

8. Costs applicable to services, facilities and supplies furnished to the provider by organizations related to the provider by common ownership or control are excluded from allowable cost of the provider if it exceeds the cost to the related organization. Therefore, such cost must not exceed the lower of actual cost to the related organization

or the price of comparable services, facilities or supplies that could be purchased elsewhere.

9. Costs of providing services and/or treatment to individuals who have not met the required eligibility criteria for the program/site.

10. Cost for contributions made to contingency reserve funds where such funds did not have prior approval by the appropriate DMH office. Contingencies do not include pension funds, self-insurance funds or funded depreciation accounts mandated by DMH offices.

11. Costs related to the purchase of alcoholic beverages.

12. Compensation to members of a Community Mental Health, Mental Retardation and Alcoholism Services Board, in excess of expenses incurred in the performance of official duties.

13. Costs for mental health clinics or other services operated exclusively in conjunction with schools. (Applicable to Aid to Localities funding only).

14. Costs associated with local governmental legislative bodies or executive staff not associated with the provision of DMH services.

15. Costs of books, subscriptions or periodicals which are not addressed to the provider agency.

16. Costs associated with the conferring of gifts or providing cash payment to an individual when the primary intent is to confer distinction on, or to symbolize respect, esteem or admiration for the recipient. If such gifts or honoraria constitute acknowledgement for services rendered, such as a speaker's fee, such costs are allowable.

17. Real estate taxes (except if part of a lease agreement or if part of purchase agreement), excise taxes on telephone services and other use taxes where organizations are eligible for exemptions from such taxes.

18. Costs incurred prior to the approved beginning date of a new program/site or expansion of a program/site unless such costs are specifically approved in writing by the required DMH office.

19. Costs incurred by a service provider that does not have an approved operating certificate or provider agreement where required, to render the particular services.

20. Costs associated with operating New York State Department of Motor Vehicle Drinking Driver programs including a prorated share of administration costs. (OASAS Only).

21. Fees for psychiatric examinations under the Criminal Procedures Law or Family Court Act including fees paid to State employees if the examination is conducted during normal

working hours (except for reasonable transportation expenses); fees paid to State employees if not accompanied by documentation from the County Fiscal Officer that there is a shortage of examiners in the county; fees above $200 for one (1) person including both an examination and court appearance.

22. For programs funded through Aid to Localities, costs representing capital additions or improvements are unallowable as operating expenses (Title 14 NYCRR) unless specifically authorized in a legislative appropriation.

23. Unless specified judicially, the cost of services provided to an agency or a program participant of an agency in legal actions against the State.

24. For programs receiving funding through Aid to Localities, the costs associated with debt service, whether principal or interest are unallowable (Title 14 NYCRR). These operating costs may include that part of rental costs paid to those community health or mental retardation service companies that represent interest paid on obligations incurred by such companies organized pursuant to Article 75 and who participated in mortgage financing in accordance with Chapter 1304 of the Laws of 1969.

25. Costs associated with depreciation of assets purchased in whole or in part with State and/or Federal funds are unallowable. The provider's share of such depreciation is allowable based upon the proportional share of the asset purchased by provider funds. Do not make adjustments for assets purchased from fees, rates or net deficit funding. *Note: If asset purchases with a value of $1,000 or more and a useful life of two years or more have been expensed for claiming purposes on Schedules DMH-2 and DMH-3, the corresponding depreciation should not be included as an expense on DMH-2 and DMH-3. Please refer to the equipment and property adjustment tables within DMH-2 instructions.*

26. Agency payment of individual employee professional licensing and/or credentialing fees.

27. Where appropriate, costs that need approval by the Division of Budget and approval has not been received.

28. Expenses that are not reasonable and/or necessary for providing services.

29. Fringe benefit expenses that are not reasonable and available to all employees.

30. Expenses that are prohibited by Federal, State or local laws.

31. Expenses included as a cost of any other program in a prior, current or subsequent fiscal period.

32. Costs of investment counsel and staff and similar expenses incurred solely to enhance income from investments.

Hospitals receiving funds from DMH via direct and/or indirect contracts are required to complete an abbreviated CFR which records with reasonable accuracy, discrete DMH costs.

The Institutional Cost Report (ICR) and the Medicaid Stepdown are not required to be submitted to DMH by the hospitals.

The following procedures are to be used exclusively by hospitals in filling out Schedule DMH-2.

The CFR is to be completed by hospitals using this manual as a guide.

In calculating expected administrative and overhead expenses, use the most recent available allocation percentages from the stepdown derived from the last Institutional Cost Report (ICR) submitted to the Office of Health Systems Management. Follow this procedure unless there is reason to believe that there will be a change in the percentage that will be allocated to Mental Hygiene programs.

If ICR stepdown percentages are not used, please so indicate and explain the methodology used to calculate the percentages.

The logical integrity between the schedules in the CFR must be maintained as prescribed throughout the manual.

Hospitals who received State Aid based on a line item expense reimbursement methodology will continue to receive State Aid in this manner (based upon the procedures outlined above).

Hospitals who previously received State Aid based on approved Medicaid rates rather than on a line item expense reimbursement methodology will continue to receive State Aid based upon their approved Medicaid rates.

When the DMH allocates deficit funding to a service provider, it is expected that these limited resources will be maximized on behalf of mental hygiene recipients. Specifically, this means that surpluses for approved mental hygiene programs should be utilized to offset deficits in other approved mental hygiene programs, thus allowing for optimal use of DMH State dollars.

With an effort to continue to maximize State Aid dollars and to establish a consistent in-contract/out-of-contract policy, the following policy for OMH funded agencies was implemented July 1, 1994 for the New York City region and January 1, 1995 for all upstate regions:

OMH Policy Statement: In-Contract/Out-of-Contract Reporting

The following medicaidable, ambulatory mental health programs must be reported as in-contract, even if net deficit funding is not supporting the program: Clinic Treatment; Continuing Day Treatment; Partial Hospitalization; Intensive Psychiatric Rehabilitation Treatment (IPRT); Intensive Case Management (ICM), Supportive Case Management (SCM); Assertive Community Treatment (ACT); and Day Treatment. Profits from any one of these programs must be used as an offset against net deficit funding in all other mental health programs except Community Residence, Family-Based Treatment, Personalized Recovery Oriented Services (PROS) and Sheltered Workshop Programs. Inpatient programs will continue to be eligible for out-of-contract status at the discretion of the OMH Community Budget and Fiscal Liaison Units and therefore profits from these programs would not be used to reduce deficits in the above-listed programs.

Although Community Residence, Family-Based Treatment, PROS, and Sheltered Workshop Programs are considered to be in-contract programs, by virtue of receiving State Aid net deficit funding, exempt income generated by one of these residential programs is not required to be used to offset in-contract deficits.

OMH Procedure: Reporting of In-Contract/Out-of-Contract

The Consolidated Budget Report (CBR) must continue the practice of containing all mental hygiene program activities by providers. Programs that are designated as in-contract must be listed by the appropriate funding source code on Schedule DMH-3 (Program Funding Summary) of the CBR, while those that are eligible to be designated as out-of-contract are to be reported under funding source code 090-Nonfunded. As a reminder, all programs that are designated as in-contract on the CBR must continue to be reported as in-contract on the Consolidated Claims Report (CCR).

Profits (except for exempt income defined above) generated by a provider from programs designated as in-contract are to be used to reduce the net deficit payable to that provider's other in-contract programs except the following OMH programs: Community Residence; and Family-Based Treatment and Sheltered Workshops. Application of these profits will be made during the desk audit of the CCR.

Not included in this manual.

Please see the Consolidated Fiscal Reporting and Claiming Manual.

Reserve for Future Use.

Local Governmental Units (LGUs) and municipalities that are required to submit a certified Consolidated Fiscal Report (CFR) may use the Compliance Review in lieu of the accountant's certification which appears on Schedule CFR-ii/CFR-iiA. The Compliance Review is intended to ensure that a CFR has been subjected to certain agreed upon procedures specified by the Department of Mental Hygiene (DMH). The Compliance Review must include the Document Control Number (DCN) of the CFR submission that was reviewed.

The certification must address the following for agreed upon procedures:

- Verification that there is a system in place and maintained for recording data in accordance with CFR definitions.
- Verification that source documents are available to support the reported data and are maintained for DMH review and audit for a minimum of 7 years following DMH's receipt of the CFR. The data must be fully documented and securely stored.
- Verification that there is a system of internal controls to assure the accuracy of the data collection process and recording system and that reported documents are not altered. Test that documents are reviewed and signed by a supervisor as required.
- Verification that the data collection methods are adequate to support the amounts reported.
- Verification that all amounts reported can be traced to supporting documentation.
- Documentation of an analytical review of the reported data to provide evidence that the CFR is reasonable and consistent with prior reporting periods, as well as other facts known about LGU/municipality operations.

DMH has specified and agreed to a set of procedures for the independent auditor to perform to satisfy the requirements of CFR Certification. Procedures a through i, as listed below, should be performed on Schedules: CFR-1, lines 13, 16,17, 20, 41, 48, 63, 64 through 67, 69 through 107; CFR-2; CFR-3; CFR-4; CFR-4A; CFR-5; DMH-1; OMRDD-3; OMRDD-4; and OMH-1.

a. Obtain and review the Consolidated Fiscal Reporting Manual, as it relates to the schedules listed above.

b. Discuss the procedures (written or informal) with the personnel assigned responsibility of supervising the preparation and maintenance of the CFR to ascertain:

    - The extent to which the LGU/municipality followed the established procedures on a continuous basis; and
    - Whether they believe such procedures are adequate to result in accurate reporting of data required by the CFR.

c. Inquire of same person concerning the retention policy that is followed by the LGU/municipality with respect to source documents supporting the CFR.

d. Based on a description of the procedures obtained in items b and c above, identify all the source documents which are to be retained by the LGU/municipality for a minimum

of seven years. For each type of source document, observe that the document exists for the period.

e. Discuss the system of internal controls with the person responsible for supervising and maintaining the CFR data. Inquire whether personnel independent of the preparer reviews the source documents and data summaries for completeness, accuracy and reasonableness and how often such reviews are performed. Perform tests, as appropriate, to ensure these reviews are performed.

f. Test the mathematical accuracy of the report.

g. Ensure summarization schedules agree to detail schedules, as prescribed by the CFR Manual.

g. Obtain the supporting worksheets/reports utilized by the agency to prepare the final data which are transcribed to the CFR. Compare the data included on the worksheets to the amounts reported in the CFR. Test the arithmetical accuracy of the summarizations.

h. Verify that the CFR software used to prepare the CFR is approved for the CFR reporting period.

i. Verify that the books and records fully support the total of each amount entered on each line of the specified CFR schedules. Identify significant reconciling items and conclude on their propriety.

The auditor must document the specific procedures followed, personnel interviewed, documents reviewed, and tests performed in the work papers. The work papers should be available for DMH review for a minimum of seven years following the CFR report year.

The auditor may perform additional procedures which are agreed to by the auditor and the LGU/municipality, if desired. The auditor should clearly identify the additional procedures performed in a separate attachment to the certification report as procedures that were agreed to by the LGU/municipality and the auditor, but not by DMH.

CFR Agreed Upon Procedures Report Format:

The following is a suggested certification format for CFR data, and is strongly recommended:

Community Mental Health Board
(name of LGU/municipality)

We understand that the (name of LGU/municipality) receives Medicaid reimbursement and/or Aid to Localities for programs funded by the New York State Department of Mental Hygiene (DMH) and in connection therewith, the LGU/municipality is required to report certain information to DMH.

DMH has established the following standards with regard to the data reported to it in the Consolidated Fiscal Report (CFR):

- A system is in place and maintained for recording data in accordance with CFR definitions.
- Source documents are available to support the reported data and maintained for DMH review and audit for a minimum of seven years following DMH's receipt of the CFR. The data are fully documented and securely stored.
- A system of internal controls is in place to assure the accuracy of the data collection process and that the recording system and reported documents are not altered. Documents are reviewed and signed by a supervisor, as required.
- The data collection methods are adequate to support the amounts reported.
- Reported amounts agree to supporting documentation.
- Reported amounts are consistent with prior reporting periods and other facts known about LGU/municipality operations.

We have applied procedures to the data contained in the accompanying CFR with Document Control Number _____, for the fiscal year-ending (date). Such procedures, which were agreed to and specified by DMH, were applied to assist you in evaluating whether the LGU/municipality complied with the standards described in the second paragraph of this report. Additional procedures performed, which are agreed to by the LGU/municipality but not by DMH, are described in a separate attachment to this report. This report is intended solely for your information and DMH, and should not be used by those who did not participate in determining the procedures.

The following information and findings came to our attention as a result of performing the procedures described in the attachments to this report.

Itemize all information and findings. If none, so state.

The agreed upon procedures are substantially less in scope than an examination, the objective of which is an expression of an opinion on the CFR. Accordingly, we do not express such an opinion. Also we do not express an opinion on the LGU's/municipality's system of internal control taken as a whole.

In performing the procedures, except for the information and findings described above, no matters came to our attention which caused us to believe that the information included in the CFR for the fiscal year-ending (date) is not presented in conformity with the requirements established by DMH. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report relates only to the information described above, and does not extend to the LGU's/municipality's financial statement taken as a whole.

The following guidelines are to be used for the purpose of budgeting and claiming Medicaid Revenue from: (a) Comprehensive Outpatient Program (COPS), (b) Community Support Program (CSP), and (c) Level II COPS fee supplement.

General Instructions

(a) For Article 31 and D&TC providers, COPS, CSP, and Level II COPS revenue should be reported on the CBR and CCR on the cash basis of accounting consistent with Section 3.0 of the CBR manual (the Methods of Accounting Section). This reporting requirement was implemented for the purpose of preventing discrepancies between the reserve amounts (overpayments) calculated by providers, and the revenue reconciliations calculated by the OMH.
(b) For Article 28 providers, COPS and CSP revenue should be reported on the CBR and CCR on the accrual basis of accounting.
(c) For all providers, COPS, CSP, and Level II COPS revenue should be reported on the core CFR schedules (CFR-1 through DMH-1) on the accrual basis of accounting in the column of the licensed outpatient program which generated the revenue up to the threshold limit. COPS, CSP, and Level II COPS revenue received over the threshold limit must be reported on Line 39 - Other Non-GAAP Adjustments of the DMH-2.
(d) To assist providers in properly segregating and tracking their COPS/CSP/Level II COPS Medicaid revenue, and identify any revenue that was received in excess of the threshold, OMH has designed a worksheet to help aid in this process. The worksheet is located at the end of this appendix.

COPS

COPS providers have the potential to generate COPS revenue in excess of the COPS threshold (the COPS threshold represents the 110% COPS amount (110% of corridor eligible funding and 100% of non-corridor eligible funding (500, Non-COPS, Shared Staff) that can be retained by the provider on an annual basis)). You may receive your threshold amount from the county, the field office, or the OMH Rate Setting Unit. When COPS overpayments occur, they will be recovered by the State through the COPS overpayment recovery process by direct payment (a check) of the full amount to DOH or the 15% withhold method (a series of reductions that is no more than 15% of any Medicaid check). The recovery process is described in great detail in the letter DOH will send should a recovery take place. Therefore, it is in the best interest of all providers to monitor their COPS revenue collections, and set aside those amounts that will be recovered (amounts set aside for recoveries are also referred to as COPS reserves).

Budgeting on the CBR

(a) COPS revenue is to be budgeted on Line 17 - Medicaid of the DMH-2 in the column of the licensed outpatient program that is to generate the COPS revenue.
(b) COPS revenue is to be allocated on the DMH-3 with all other Medicaid revenue consistent with the direction provided in Section 15.0 of the CBR manual (the DMH-3 Section).
(c) COPS overpayments from prior years do not need to be included on the budget (but need to be included on the claim).

Claiming on the CCR

(a) COPS revenue is to be claimed on Line 17 - Medicaid of the DMH-2. Use the COPS line to record the COPS revenue.
(b) COPS revenue that was reported on Line 39 - Other Non-GAAP Adjustments of the previous year's DMH-2 is to be reported on Line 29 - Other Revenue of the current year's DMH-2. Record the previous year's COPS reserves (revenue in excess of the threshold (overpayments) generated during previous local fiscal years that have not yet been recovered by the State) on the COPS Prior Years line.
(c) COPS reserves (revenue in excess of the threshold (overpayments) generated during the current local fiscal year **plus** any overpayments generated during previous local fiscal years that have not yet been recovered by the State) are to be reported on Line 39 - Other Non-GAAP Adjustments of the DMH-2. Use the COPS reserve line to record the COPS reserve.
(d) COPS revenue is to be allocated on the DMH-3 with all other Medicaid revenue consistent with the direction provided in Section 24.0 of the CFR manual (the DMH-3 Section).
(e) Providers are to continue to complete the CBR and CCR on a county-specific basis. Providers who operate COPS programs that have locations in more than one county, or providers who operate COPS programs at locations in one county, but provide COPS services to residents of another county through a contractual arrangement, are to allocate COPS overpayments to the participating counties consistent with the ratio of the COPS threshold for the program type in that particular county to the agency's Total COPS threshold for that particular county.

CSP

CSP providers have the potential to generate CSP revenue in excess of the CSP threshold (the CSP threshold represents the 100% CSP amount that can be retained by the provider on an annual basis). You may receive your threshold amount from the county, the field office, or the OMH Rate Setting Unit. When CSP overpayments occur, they will be recovered by the State through the CSP overpayment recovery process by direct payment (a check) of the full amount to DOH or the 15% withhold method (a series of reductions that is no more than 15% of any Medicaid check). The recovery process is described in great detail in the letter DOH will send should a recovery take place. Therefore, it is in the best interest of all providers to monitor their CSP revenue collections,

and identify those amounts that will be recovered (amounts set aside for recoveries are also referred to as CSP reserves).

Budgeting on the CBR

(a) CSP revenue is to be budgeted on Line 17 - Medicaid of the DMH-2 in the column of the CSP program for which the revenue is intended (and not in the column of the licensed outpatient program that is to generate the revenue).
(b) CSP revenue is to be allocated on the DMH-3 with all other Medicaid revenue consistent with the direction provided in Section 15.0 of the CBR manual (the DMH-3 Section).
(c) CSP overpayments from prior years do not need to be included on the budget (but need to be included on the claim).

Claiming on the CCR

(a) CSP revenue is to be claimed on Line 17 - Medicaid of the DMH-2. Record the revenue on the CSP line.
(b) Please note: It is the responsibility of (a) the LGU (in the case of CSP programs that are funded through the State aid approval letter), or (b) the direct contract provider (in the case of CSP programs funded through a direct contract between the State and the provider), that the CCR is submitted to ensure that the CSP revenue is reported in the column of the CSP program for which the revenue is intended. In the case of providers who receive CSP revenue for CSP programs funded through both the approval letter and a direct contract, it is the responsibility of the direct contract provider to inform the LGU of the proper amount of CSP revenue that is to be reported in the columns of the CSP programs funded through the approval letter).
(c) CSP revenue that was reported on Line 39 - Other Non-GAAP Adjustments of the previous year's DMH-2 is to be reported on Line 29 - Other Revenue of the current year's DMH-2. Record the previous year's CSP reserves (revenue in excess of the threshold (overpayments) generated during previous local fiscal years that have not yet been recovered by the State) on the CSP Reserve Prior Years line.
(d) CSP reserves (revenue in excess of the threshold (overpayments) generated during the current local fiscal year **plus** any overpayments generated during previous local fiscal years that have not yet been recovered by the State) are to be reported on Line 39 - Other Non-GAAP Adjustments of the DMH -2. Providers who receive CSP revenue in more than one type of outpatient program shall identify the CSP overpayments and shall report these overpayments in the program(s) where the overpayment has been received.
(e) CSP revenue is to be allocated on the DMH-3 with all other Medicaid revenue consistent with the direction provided in Section 24.0 of the CFR manual (the DMH-3 Section).

Level II COPS

Level II COPS providers have the potential to generate Level II COPS revenue in excess of the Level II COPS threshold (the Level II COPS threshold represents the 100% Level II COPS amount that can be retained by the provider on an annual basis). You may receive your threshold amount from the county, the field office, or the OMH Rate Setting Unit. When Level II COPS overpayments occur, they will be recovered by the State through the Level II COPS overpayment recover process by direct payment (a check) of the full amount to DOH or the 15% withhold method (a series of reductions that is no more than 15% of any Medicaid check). The recovery process is described in great detail in the letter DOH will send should a recovery take place. Therefore, it is in the best interest of all providers to monitor their Level II COPS revenue collections, and set aside those amounts that will be recovered (amounts set aside for recoveries are also referred to as Level II COPS reserves).

Budgeting on the CBR

(a) Level II COPS revenue is to be budgeted on Line 17 - Medicaid of the DMH-2 in the column of the licensed outpatient program that is to generate the Level II COPS revenue.
(b) Level II COPS revenue is to be allocated on the DMH-3 with all other Medicaid revenue consistent with the direction provided in Section 15.0 of the CBR manual (the DMH-3 Section).
(c) Level II COPS overpayments from prior years do not need to be included on the budget (but need to be included on the claim).

Claiming on the CCR

(a) Level II COPS revenue is to be claimed on Line 17 - Medicaid of the DMH-2. Record the revenue on the Level II COPS line.
(b) Level II COPS revenue that was reported on Line 39 - Other Non-GAAP Adjustments of the previous year's DMH-2 is to be reported on Line 29 - Other Revenue of the current year's DMH-2. Record the previous year's Level II COPS Reserves from Line 39 - Other Non-GAAP Adjustments (revenue in excess of the threshold (overpayments) generated during previous local fiscal years that have not yet been recovered by the State) on the Level II COPS Prior Years line.
(c) Level II COPS reserves (revenue in excess of the threshold (overpayments) generated during the current local fiscal year **plus** any overpayments generated during previous local fiscal years that have not yet been recovered by the State) are to be reported on Line 39 - Other Non-GAAP Adjustments of the DMH-2.
(d) Providers are to continue to complete the CBR and CCR on a county-specific basis. Providers who operate Level II COPS programs that have locations in more than one county, or providers who operate Level II COPS programs at locations in one county, but provide Level II COPS services to residents of another county through a contractual arrangement, are to allocate Level II COPS overpayments to the

participating counties consistent with the direction provided in Section 15.0 of the CBR manual (the DMH-3 Section).

(e) Level II COPS revenue is to be allocated on the DMH-3 with all other Medicaid revenue consistent with the direction provided in Section 15.0 of the CBR manual (the DMH-3 Section).

Claiming and Reporting Worksheet For COPS, CSP, and Non-COPS

		Example:	Enter your Amounts Here:	Description
COPS Threshold		$100,000		Amount provided by the county, field office, or the OMH rate setting unit.
CSP Threshold		$100,000		Amount provided by the county, field office, or the OMH rate setting unit.
Level II -COPS Threshold		$0		Amount provided by the county, field office, or the OMH rate setting unit.
Line 17 - Medicaid:				
COPS	a)	$120,000		Current year COPS revenue minus any COPS recoveries made in the current year.
CSP	b)	$40,000		Current year CSP revenue minus any CSP recoveries made in the current year.
Level II COPS	c)	$0		Current year Non-COPS revenue minus any Level II COPS recoveries made in the current year.
Total: a + b + c		$160,000		Equals the total Medicaid Revenue
Line 29 - Other Revenue:				
CSP Reserve Prior Year	a)	$20,000		CSP Reserve from Line 39 - Other Non-GAAP Adjustments from prior year
COPS Prior Year	b)	$20,000		COPS Reserve from Line 39 - Other Non-GAAP Adjustments from prior year

		Example:	Enter your Amounts Here:	Description
Level II COPS Prior Years	c)	$0		Level II COPS Reserve from Line 39 - Other Non-GAAP Adjustments from prior year
Total: a + b + c		$40,000		Equals total prior year reserves from previous years Line 39 - Other Non-GAAP Adjustments (overpayments)
Line 39 - Other Non-GAAP Adjustments:				
CSP Reserve	a)	$20,000		Current year CSP overpayment plus prior year CSP reserve not yet recovered
COPS Reserve	b)	$40,000		Current year COPS overpayment plus prior year COPS reserve not yet recovered
Level II COPS Reserve	c)	$0		Current year Level II COPS overpayment plus prior year Level II COPS reserve not yet recovered
Total: a + b + c		$60,000		Equals current year overpayments plus any prior year reserves not yet recovered

The following is a set of guidelines which the Office of Mental Retardation and Developmental Disabilities (OMRDD) issued to all OMRDD funded service providers. The reimbursement principles became effective January 1, 1999 and set forth the decision principles by which OMRDD will determine allowed levels of reimbursement for the following categories of expense: meals, travel, professional fees and dues and subscriptions for personal purposes, entertainment, personal automobile use, agency provided vehicles, gifts, office furnishings, tuition, and housing. OMRDD will not reimburse provider expenses which exceed the guidelines contained in this document.

Costs Eligible for Reimbursement by OMRDD

The following principles shall be used by OMRDD to determine costs eligible for reimbursement:

(1.) Any cost must be related to the provision of services to consumers, the enhancement of agency staff skill and training, the direct provision of services to consumers, or the operation of the agency.
(2.) In order to be considered eligible for reimbursement, any cost is subject to the "prudent buyer" concept (i.e., the maximum spent should be what a typical buyer would reasonably expect to pay).

Meals

The cost of meals is eligible for reimbursement when staff and/or board members are in business related travel status, meeting with outside parties, or when engaged in board related business.

The cost of staff meals for those staff being honored at employee recognition events is eligible for reimbursement. In all cases, the expense of a meal includes the amount spent for food, non-alcoholic beverages, taxes and tip only.

Costs incurred by staff in the provision of direct service to consumers are considered program costs.

Travel Status

The cost of travel is eligible for reimbursement if the trip is related to the business of the agency. Expenses include the travel cost to and from the destination where the agency's business will be transacted and any business related travel expenses (e.g., lodging, car rental, parking, tolls, taxi) while at the business destination. The least costly reasonable mode of transportation is eligible for reimbursement with reasonable consideration given to the requirements of the particular business circumstances at hand.

Professional Fees and Dues and Subscriptions for Personal Purposes

Such costs are generally not eligible for reimbursement. However, costs for licensure or certification required as a condition of employment by the agency are eligible for reimbursement.

Entertainment

Costs which related solely to the amusement and diversion of staff, administration, or board members which are of no business benefit to the agency are not eligible for reimbursement.

Costs incurred by the agency in the provision of annual holiday parties or picnics or employee recognition events are eligible reimbursement, subject to the prudent buyer concept.

Costs incurred by staff in the provision of direct consumer service are considered program costs.

Personal Automobile Related

Personal commuting costs, as defined by the Internal Revenue Service for tax purposes, are not eligible for reimbursement. Costs for business related use of a personal vehicle are eligible for reimbursement if the costs are ordinary and necessary. An ordinary cost is one that is common and accepted by the industry. A necessary cost is one that is required by the agency for the benefit of the agency or its consumers and not the individual staff or board member.

Agency Provided Vehicle

Costs associated with the acquisition or lease, operation, and maintenance of an agency owned vehicle used for agency related business, or costs associated with the personal use of an agency owned vehicle which are reported on the employee's IRS W-2 form as compensation, and determined by the board in written agency policy, are eligible for reimbursement. Costs in excess of the luxury vehicle threshold, as defined by the Internal Revenue Service, are not eligible for reimbursement.

Gifts

The cost of gifts is not eligible for reimbursement. Awards given for employee recognition purposes are not considered gifts.

Office Furnishings

The cost of office furnishings and decorations considered lavish or extravagant when compared to the prudent buyer concept, is not eligible for reimbursement. Fine art and collectibles are not reimbursable.

Tuition

Cost for the training and educational enhancement of staff members are eligible for reimbursement where it can be demonstrated that such training and educational enhancement afforded the employee promotional opportunities within the agency and/or enhanced the quality of service delivery to consumers.

Housing

Costs associated with the provision of housing to agency personnel are eligible for reimbursement when the agency requires that such personnel reside on the grounds, or in close proximity to the facilities operated by the agency.