

INSTRUCTIONS FOR PREPARING THE BH FAMILY BASED RATE SETTING

** PLEASE NOTE: Upon receipt of an approved rate, the information contained in this document should be used throughout the year to monitor services. Additional expenditures not included in this approved rate are not subject to REIMBURSEMENT without prior approval from the County. REIMBURSEMENT of unapproved expenditures will not automatically occur. Expenditures are subject to Chapter 4300 Fiscal Regulations, productivity standards and program regulations.*

AGENCY PROFILE OF FAMILY BASED SERVICES

1. **AGENCY NAME:** List the complete name of the parent agency with which the Family Based (FB) Program is affiliated.
2. **AGENCY ADDRESS:** List the complete address of the above agency's main location.
3. **PROGRAM NAME:** List the FB Program Name.
4. **PROGRAM ADDRESS:** List the above FB Program's main location.
5. **TELEPHONE NUMBER:** List the FB Program's main location telephone number.
6. **LEAVE POLICY:** List days indicated for 1 average FTE. Training days must be included at a minimum of 17, not to exceed 24 days. Other days must be defined. Vacancy days are limited to 30 and based on program history, and still limited to an average per FTE.
Total number of days = 6G.
7. **NON-AVAILABLE WEEKS:** Divide the total number of days in Item 6G by 5 (days per week) to determine non-available weeks.
8. **TOTAL AVAILABLE WEEKS:** Subtract the non-available weeks in Item 7 from 52 (weeks) to determine available weeks.
9. **FTE HOURS PER WEEK:** The number of hours per week that constitute a full-time equivalent.
- 10 -11. **UOS PER FTE:** Multiply Item 8 by FTE hours/week; multiply by 4 (1/4 hour UOS); multiply by 60% productivity; apply a 40% time factor for team member UOS and a 60% time factor for team UOS. Multiply by 50% for team UOS per person.
12. **PERSON COMPLETING FORM:** List the Name of the person authorized to submit a Rate Setting Package to the County.
13. **TELEPHONE NUMBER:** List the telephone number of the Person above.
14. **SUBMISSION DATE:** List the date this package (or revised package) is being submitted to the County OMH.

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FAMILY BASED DIRECT SERVICE STAFF

LIST THE FB PROGRAM NAME.

NAME: Indicate the Last Name and First Name of any full-time, qualified, service providing staff person employed by the Agency who receives any part of their salary from FB funds. Include anticipated vacancies.

FUNCTIONAL TITLE: The only acceptable titles are: MHP – Mental Health Professional
MHW Mental Health Worker

DATE OF HIRE: Indicate the date of hire in the FB Program per individual. If a position is vacant, indicate the anticipated date of hire.

12 MONTH ANNUAL SALARY AND BENEFITS: Indicate the annual 12 month salary and benefits paid to each individual by the parent agency.

PROGRAM SALARY AND BENEFITS: Indicate the 12-month or part-year salaries and benefits directly related to FB. Part-year costs must be pro-rated from the anticipated date of hire or calculated pro-rata for planned leaves of absence.

EDUCATION/EXPERIENCE LEVEL: List the corresponding CODE for the highest level attained, choosing from the following list:

- MHP - D11 - Graduate degree in accordance with proposed Chapter 5260.23 c (1)
- D12 - Licensed registered nurse in accordance with proposed Chapter 5260.23 c (2)
- D13 - Bachelor degree in accordance with proposed Chapter 5260.23 c (3)

- MHW - D14 - Bachelor degree in accordance with proposed Chapter 5260.23 d (1)
- D15 - High school diploma plus 12 college level credits in accordance with proposed Chapter 5260.23 d (2)
- D16 - Licensed registered nurse in accordance with proposed Chapter 5260.23 d (3)

FULL TIME OR PART TIME EQUIVALENCY: Indicate whether the staff person is considered a full-time (F) employee or a part-time (P) employee during this time period.

ANNUAL UNITS OF SERVICE: Combine the total number of team units of service and member units of service budgeted for teams identified above. Then, calculate the percentage of team units and the percentage of member units to monitor billable activity.

SUBTOTAL SALARY/BENEFITS & UOS - Indicate a subtotal of program salary and benefits and projected Team and Team Member units of service

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FAMILY BASED ADMINISTRATIVE SUPPORT BOTH STAFF/SUPERVISORY STAFF

LIST THE FB PROGRAM NAME

NAME: Indicate the Last Name and First Name of each direct service support staff person employed by the agency who receives any part of their salary from FB funds. Indicate the Last Name and First Name of any administrative support staff person employed by the agency who receives 20% or more of their salary from FB funds. Administrative support staff whose portion of salary is less than 20% should be included in administrative costs claimed on page 5.

FUNCTIONAL TITLE: Indicate, by CODE, a title which explains each individual's function within the FB Program. For Supervisory personnel, PD (Program Director) and FBS (Family Based Supervisor) are the only options. For Administrative Support staff, choose the appropriate functional title from the following CODES:

AMDS - Administrator	CLCS - Clerical Support	FISC - Fiscal Support
BILS - Billing Support	DATA - Data Support	PSYC - Psychiatrist
BUSM - Business Manager	EXCD - Executive Director	OTHS - Other Support

DATE OF HIRE: Indicate the date of hire in the FB Program for each individual.

12 MONTH ANNUAL SALARY AND BENEFITS: Indicate the annual 12 month salary and benefits paid to each individual by the parent agency.

PROGRAM SALARY & BENEFITS: List the portion of each individual's salary and benefits that is directly related to FB.

SUPPORT STAFF ONLY

TOTAL SUPPORT HRS/WEEK: List the total number of hours per week each individual listed is assigned to the FB Program.

SUBTOTAL SALARY & BENEFITS: Indicate a subtotal of program salary and benefit amounts

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SUPERVISORY STAFF ONLY

EDUCATION/EXPERIENCE LEVEL (SUPERVISORY ONLY): List the highest level attained by choosing from the following list:

- Project Director:** S8 - Graduate degree in accordance with proposed Chapter 5260.23 b (1)
S9 - Supervisor certificate from AAAMFT in accordance with proposed Chapter 5260.23 b (2)
S10- Bachelor degree in accordance with proposed Chapter 5260.23 b (3)

- Clinical Consul.:** S11- Psychiatrist
S12- Masters degree in accordance with proposed Chapter 5260.23 b (3) (i) & (ii)

HOURS PER WEEK:

DIRECT SERVICE VS. SUPERVISION HOURS PER WEEK: Indicate the hours per week in direct service versus supervision.

TOTAL FB HOURS/WEEK: Indicate a cumulative total of direct service and supervision hours per week.

FULL TIME OR PART TIME EQUIVALENCY: Indicate whether the staff person is considered a full-time (F) employee or a part time (P) employee during this time period.

ANNUAL UNITS OF SERVICE: Indicate units anticipated by supervisors. These units are not subject to productivity standards.

SUBTOTAL SALARY & BENEFITS AND UOS: Indicate a subtotal of program salary and benefit amounts and UOS for Supervisors.

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FAMILY BASED CONTRACT STAFF

LIST THE FB PROGRAM NAME

NAME: Indicate the Last Name and First Name of any person contracted by the agency who receives any part of their compensation from FB funds.

FUNCTIONAL TITLE: Indicate the functional title of individuals, which explains their function within the FB M Program. Contract staff function CODES must come from the table below:

AMDS - Administrator	CLCS - Clerical Support	FISC - Fiscal Support
PD - Program Director	BILS - Billing Support	DATS - Data Support
PSYC - Psychiatrist	FBSV - Supervisor	BUSM - Business Manager
EXCD - Executive Director	OTHS - Other Support	

CONTRACT AMOUNT

AGENCY: List the total amount of the contract this individual holds with the agency.

FBMHS : List the amount of the above contract that is charged to the FB Program.

NOTE - Programs are encouraged to include psychiatric consultation time with FB to better serve consumers. Refer to OMH Bulletin OMH-95-01 for maximum allowable rates of reimbursement for psychiatrists.

ANNUAL HOURS IN PROGRAM: List the total number of annual hours for which an individual is contracted with the FB Program.

HOURLY RATE: Divide the FBMHS Contract Amount by the total number of hours per year in the FB Program.

SUBTOTAL, PROGRAM CONTRACT AMOUNT: Indicate a subtotal of FB contracted amount(s) for Contract Staff.

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FAMILY BASED OTHER COMPENSATION BUDGETED

LIST THE FB PROGRAM NAME

OVERTIME: Indicate the dollar amount and Units Of Service (quarter hours) anticipated in time worked beyond the regular workday. Divide the overtime dollar amount by the UOS to determine cost per UOS. Finally, indicate the calculation method used to calculate overtime dollar amount and Units Of Service.

ON-CALL: Indicate the dollar amount and Units Of Service (quarter hours) anticipated in time worked beyond the regular workday. Divide the on-call dollar amount by the UOS to determine cost per UOS. Finally, indicate the calculation method used to calculate on-call dollar amount and Units Of Service.

OTHER: Indicate the dollar amount and Units Of Service (quarter hours) anticipated in time worked beyond the regular workday. Divide the "Other Dollars" amount by the UOS to determine cost per UOS. Finally, indicate the calculation method used to calculate the "Other Dollars" amount and Units Of Service.

TOTAL: Calculate the combined total dollar amount and Units Of Service for overtime, on-call and other.

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FAMILY BASED NON-PERSONNEL COST

Indicate the costs of each item in the amount they can be applied to FB in accordance with Chapter 4300 County MH/MR Fiscal Manual. Items 4b, 6b, 8, 10, and 11 require attachments with explanation.

Item 1 - Staff Development should include the total cost of attending mandated FB Training. (\$2,500 per two teams).

Item 2 - Training should include the cost of additional training not included in Item 1.

Item 3 - Occupancy should separately identify:

A. Rent pro-rated in direct relation to the amount of space used by the FB Program.

The cost may not exceed the rental rate for similar space in that geographic area.

B. Maintenance pro-rated in direct relation to rent.

C. Housekeeping pro-rated in direct relation to rent.

D. Utilities pro-rated in direct relation to rent.

Item 4 - Supplies should separately identify:

A. Office Supplies necessary in the delivery of service.

B.* Other supplies necessary in the delivery of service, if applicable.

Item 5 - Communications necessary in the delivery of service and separately identified by:

A. Telephones

C. Postage/Shipping

B. Beepers/pagers.

D. Printing.

Item 6 - Equipment and furniture essential to program operation separated by:

A. Routine purchases of \$500 or less.

B. * One-time only purchases of equipment valued at more than \$500 per item.

Item 7 - Travel should include only the cost of travel reimbursement when employees use their own vehicles (if applicable) and/or fees necessary for staff to perform FB functions, e.g., bus or subway fees.

Item 8* - Indicate the number of vehicles the FB Program has and vehicle costs related to:

A. Maintenance

C. Lease or Purchase

B. Repairs

D. Vehicle Insurance

Item 9 - Indicate Insurance costs to protect against:

A. Casualty

B. Theft

C. Liability

Item 10* - Unless administrative costs are specifically itemized, an approved cost allocation plan must be attached to this page. Only those costs directly related to the FB Program may be apportioned. Administrative staff who are employed less than 20% of FTE in FB should also be included here.

Item 11* - Other allowable costs must be clearly identified when included.

TOTAL NON-PERSONNEL COSTS: Indicate the total of all costs included in Items 1 through 11.

FISCAL YEAR 2007 BUDGET: *Indicate the total of each item budgeted for FY07.*

FISCAL YEAR 2005 ACTUALS: *Indicate the total of each item expensed during FY05.*

JUL-DEC FY 2006 ACTUALS: *Indicate the total of each item expensed during the first six months of FY06.*

INSTRUCTIONS FOR PREPARING THE BH FAMILY BASED RATE SETTING

FAMILY BASED SUMMARY OF SERVICES AND COST

- 1. TOTAL PROGRAM COSTS:** This is a combined total derived from the following:
 - pages 2-4 Total of program salaries and benefits for direct service staff, direct service support staff, administrative support staff, supervisory staff, contract amount, plus
 - page 5 Total Other Compensation dollar amount, plus total non-personnel costs.

- 2. APPROVED FY 2006 RATE: Enter the approved Rate from Fiscal Year 2006.**

- 3. TOTAL NUMBER OF CONSUMERS:** Indicate the total number of consumers to be served during fiscal year 2007. Of the number projected, identify the number that are expected to be CBH (MA), MA Fee For Service and Uninsured.

- 4. TOTAL UNITS OF SERVICE:** Indicate the total units of service to be provided. Of the units projected, identify the number that are expected to be CBH (MA), MA Fee For Service and Uninsured.

INSTRUCTIONS FOR PREPARING THE BH FAMILY BASED RATE SETTING

FAMILY BASED CLIENT CONTINGENCY FUNDS

COUNTY REIMBURSABLE COSTS:

List those service costs that are not subject to federal financial participation and are therefore County reimbursable only. This is limited to funds for emergency food, emergency clothing, emergency shelter, and client transportation. *NOTE: COUNTY REIMBURSABLE COSTS CANNOT EXCEED 10% OF THE TOTAL PROGRAM COSTS (page 6, ITEM 1).*

FAMILY BASED PURCHASED SUPPORT SERVICES

TYPE OF SERVICE: Family support services are those services that are provided directly to or for FB clients. They are necessary in the provision of quality FB service. Services should be coordinated via the FB project director. Indicate each type of family support service being purchased by choosing from the following CODE numbers:

- 01 - Respite
- 02 - Transportation
- 03 - Family Aide
- 04 - Community Programs
- 05 - Household Needs
- 06 - Registration Fees
- 07 - Other

CONTRACT AMOUNT: Indicate the total number of hours and the total dollars of the contract that are applied to the FB program.

NUMBER OF CONSUMERS: Indicate the number of consumers to be served in each purchased services category.

SUBTOTALS AND PRIOR YEARS ACTUALS: Indicate a subtotal in both hours of service to be purchased and contract dollar amounts to be expended, as well as corresponding subtotals for all of FY 2005 and for Jul-Dec of FY 2006.

MINIMUM PURCHASED SERVICES REQUIRED: Family support services dollars must be included in an amount equal to at least 5%, not to exceed 10% of the total FB Budget (i.e. Page 6, item 1, PLUS purchased family support services).

INSTRUCTIONS FOR PREPARING THE INTENSIVE CASE MANAGEMENT & RESOURCE COORDINATION FORMS

- 1 – 5 Provide Agency Profile
- 6 - 10 Calculate UOS per full-time FTE at 75% productivity using the formulas given
- 11 – 14 Provide the number of individual staff persons and the cumulative FTEs they represent
- 15 Provide the number of agency-employed psychiatrists participating in the program, the cumulative FTEs they represent, and the number of psychiatric hours per week available to the program.
- 16 Provide the number of psychiatrists, FTEs they represent, and hours per week assigned to the Program from purchased personnel (*contracted psychiatric support*)
- 17 List the budgeted costs of on-call and other (*specified*) compensation, the units of service generated by the activity, and the cost per unit of service.
- 18 – 19 List the number of vehicles assigned to the case management program, and for each vehicle, the Make, Model and Year
- 20 Provide the total Program Costs (*total eligible costs as reported on line “F” of the Expenditure Summary for the respective PAC*). Do NOT include client contingency funds, as these are a separate PAC.
- 21 Enter the approved FY 2006 rate
- 22 Provide the number of consumers to be services (*caseload size*) and of those the number that are CBH (MA), MA Fee for Service or Uninsured (*Zero Liability*)
- 23 Provide the total units of service to be delivered, and of those, the number that are CBH (MA), MA Fee For Service or Uninsured (*Zero Liability*)

INSTRUCTIONS FOR PREPARING THE BH RESIDENTIAL EXPENDITURE SUMMARY

I. PURPOSE:

This form is used to summarize and report budgeted or actual expenditures and revenues by the line item classifications that are required by the account structure of the Pennsylvania Department of Public Welfare.

II. GENERAL INSTRUCTIONS:

- A. The form is to be completed by individual residential site for each distinct Mental Health Program Residential PAC authorized by the OBH/MRS.
- B. Multiple sites can be entered on this form. Use as many forms as necessary to report all sites within an authorized PAC. The last column of this form should be used to report the total of all sites and these totals must correspond to the totals reported on the Program Activity Invoice Summary (for invoicing) and the Summary of Program Activity (for budgeting).

III. PREPARING THE FORM:

- A. Heading: Check the appropriate “invoice” or “budget” blocks. Enter agency name, program activity, PAC code, PAC name, date submitted, and period covered.
- B. Residential Site Address: Enter by individual site the address number, name of street, road, avenue, and apartment number, letter or floor where applicable.
- C. Slot Capacity: Enter the number of slots that are charged to the respective PAC for each individual site (including vacant slots). Do not include the actual number of individuals served in each site.
- D. Classifications:
 - 1. Personnel Services:
 - a. Wages & Salaries: Enter the wage and salary totals
 - b. Employee Benefits: Enter amounts for employee benefit expenses for the program activity.
 - c. Purchased Personnel: Enter the amounts for Purchased Personnel (include temporary help and professional practitioners and consultants who are not regular employees).

INSTRUCTIONS FOR PREPARING THE BH RESIDENTIAL EXPENDITURE SUMMARY

- d. Other Personnel Expense: Enter amounts for other personnel expenses such as professional fees, purchased payroll processing, etc. for the program activity.
 - e. Staff Development: Enter amounts for staff development.
 - f. Sub-Total Personnel: Enter the sub-total for personnel expenses for each PAC.
2. Operating Expenses: Enter amounts for all applicable operating expenditure (rent, utilities, etc) and equipment/assets expenditures (building repairs, building renovations etc) within this category and enter the sub- totals for operating expenses. This sub-total must equal the amount of operating expenditures on the Summary of Program Activities (for budgeting) and Program Activity Invoice Summary (for invoicing).
 3. Total Direct: Enter sub-total for all direct costs/expenditures reported. The amount reported on Total Direct line should equal the sum of the sub-totals of Sections A, and B.
 4. Administration: Enter amounts for administration as reported on the Administrative Cost Distribution Schedule.
 5. Total Eligible Costs: Enter total of Direct Cost plus Administration

Note: After completing total eligible costs, the provider should determine the percentage relationship between eligible administration and total eligible costs. If administrative expenditures exceed the cap, the amount necessary to reduce administrative expenditures to the cap is deducted from eligible administrative expenditures. When the amount of eligible administration is determined for the program activity, it is carried forward to the Summary of Program Activities and/or Program Activity Invoice Summary.

6. Revenue: Enter revenue from all sources that the provider is required to report as an offset to eligible expenditures. Amounts reported for the individual revenue sources should be totaled and this amount reported on the Program Activity Invoice Summary and/or the Summary of Program Activities.
7. Net to Be Funded: Enter the amount of funding requested from the OBH/MRS (Total Eligible Costs minus Total Revenue).
8. Retained Revenue: Enter the amount claimed as Retained Revenue Allowance (RRA). Refer to final invoice instructions for the allowability and limitations of the RRA.

INSTRUCTIONS FOR PREPARING THE BH RESIDENTIAL EXPENDITURE SUMMARY

9. Net Eligible Including Retained Revenue: Enter in the combined amount of Net to be Funded plus the Retained Revenue Allowance.

10. Ineligible Expenditure: Report expenses which are ineligible for reimbursement by the DBH/MRS. Expenses which are not incurred in compliance with DBH/MRS Program regulations or otherwise do not conform with reimbursement policy of the DBH/MRS are reported in this column.