

CODAAP - EXHIBITS

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FY'97 CODAAP SERVICE OBJECTIVES INSTRUCTIONS FOR OUTPATIENT

AGENCY NAME: Enter the Corporate name shown at the top of the Allocation Sheet.

FACILITY #: Enter the six digit identification number assigned to the facility by ODAP's licensing division.

FACILITY ADDRESS: Enter the facility(ies) street addresses).

FACILITY NAME: Enter the name(s) used to identify the facility(ies). This should be the same as the Facility Name on the Allocation Sheet across from the funding amount.

1. **TOTAL AGENCY SLOTS** Enter the total number of slots (static capacity) funded at this facility regardless of funding source.
2. **CODAAP FUNDED SLOTS:** Enter the number of slots (static capacity) funded by the CODAAP allocation at this facility.
3. **ADMISSIONS:** Enter the projected number of persons to be admitted to the facility during the funding period.
4. **NUMBER OF CLIENTS TO BE SERVED:** Enter the projected number of clients to be served during FY'97. This equals the projected census on July 1, 1996 plus projected admissions (line 3).
5. **CLIENT VISITS, METHADONE DISPENSING:** Enter the projected number of methadone dispensing visits to be made by clients at the facility during the funding period.
6. **INDIVIDUAL COUNSELING HOURS:** Enter the projected number of individual counseling hours to be provided by the facility during the funding period.
7. **GROUP COUNSELING:**
 - a) **STAFF HOURS:** Enter the projected number of hours to be spent by counseling staff members in the provision of group counseling services to active clients.
 - b) **CLIENT HOURS:** Enter the projected total number of group counseling client hours to be provided during the funding period. This equals line 7a multiplied by the projected average group size.
8. **TOTAL STAFF HOURS, COUNSELING:** Enter the sum of the entries on lines 6 and 7a to obtain the projected total direct service staff hours to be provided during the funding period.

(continued)

NOTE: THIS NUMBER SHOULD REFLECT A MINIMUM OF 924 HOURS PER FULL TIME COUNSELOR EQUIVALENT AS ENTERED ON LINE 15.

REMEMBER, WHAT IS BEING ASKED FOR HERE ARE SPECIFIC HOURS RELATIVE ONLY TO COUNSELING. ADDITIONAL SERVICE HOURS PROVIDED BY STAFF MAY BE PROJECTED ON LINE 10, ENTITLED "SUPPORT SERVICE INTERVENTIONS."

9. TOTAL CLIENT HOURS, COUNSELING: Enter the sum of the entries on lines 6 and 7b to obtain the projected total number of client hours to be provided during the funding period.

10. SUPPORT SERVICE INTERVENTIONS: Indicate the projected number of staff hours in support service interventions to be provided to clients by counseling staff during their program enrollment. These interventions should not be confused with counseling service hours and not include service hours provided by agency case managers. They should include but not be limited to the following areas:

- | | | |
|----------------|------------------|---------------|
| a) legal | b) medical | c) vocational |
| d) educational | e) recreational | f) family |
| g) housing | h) mental health | i) welfare |

11. NUMBER OF DIRECT SERVICE HOURS PROVIDED BY CASE MANAGERS: Indicate the projected number of face to face service hours between Case Managers and clients to be provided during FY97.

Only information effecting Case Managers hired by the agency need be included in these sections.

12. NUMBER OF INDIRECT SERVICE HOURS PROVIDED BY CASE MANAGERS: Indicate the projected number of non direct service hours (i.e., phone calls to welfare,, CJS, meetings with housing providers, etc.) to be provided by case managers during FY'97.

13. NUMBER OF SERVICE HOURS PROVIDED TO CHILDREN: Indicate the number of direct and indirect staff service hours to be provided to children of clients enrolled in your program during the funding period.

14. PHYSICAL/PSYCHIATRIC EXAMS: Enter the number of projected physical/psychiatric exams to be provided to clients at your facility during the funding period.

15. **NUMBER OF FULL TIME COUNSELOR EOUIVALENTS:** Enter the number of full time counselor equivalents projected for the funding period. A full time counselor equivalent (FTE) is an employee working a minimum of 35 hours per week providing individual and/or group counseling at the facility. This number should be obtained by adding the appropriate number of counselor equivalents reflected on the Personnel Roster of the program funded budget form. If a supervisor or administrative staff member is also providing direct counseling to clients, that portion of such staff person's time spent in counseling should also be included in the total projection. The calculation of FTE's is best done by adding the total weekly hours to be provided by counselors to the number of counseling hours to be provided by administrative supervisory, or other staff, and dividing this sum by the number of hours in the normal work week of full time staff of the facility.
16. **NUMBER OF FULL TIME CASE MANAGER EOUIVALENTS:** Enter the number of full time case manager equivalents projected for the funding period. A full time case manager equivalent (FTE) is an employee working a minimum of 35 hours per week providing case management services at the facility. This number should be obtained by adding the appropriate number of case manager equivalents reflected on the Personnel Roster of the program funded budget form. If a supervisor or administrative staff member also provides case management to clients, that portion of such staff person's time should also be included in the total projection. The calculation of FTE's is best done by adding the total weekly hours to be provided by case manager to the number of case management hours to be provided by administrative supervisory, or other staff, and dividing this sum by the number of hours in the normal work week of full time staff of the facility.

DATE SUBMITTED: Enter the actual date the form is submitted to CODAAP.

SUBMITTED BY: The person responsible for preparing the facility information included on this form (i.e. the facility Director) should sign here.

NAME AND TITLE: Type the name and title of the person who signs this form for the facility.

EFFECTIVE DATE OF CHANGE: Use this line only for a Service objectives revision during the fiscal year.

APPROVED BY: Leave this blank. Final accepted Service objectives Forms will be signed by the Assistant Health Commissioner for CODAAP and appended to your contract. You will be required to achieve the levels of services indicated on the approved Service Objectives Form.

FY'97 CODAAP SERVICE OBJECTIVES PROJECTIONS OUTPATIENT
(SEE INSTRUCTIONS BEFORE ATTEMPTING TO COMPLETE THIS FORM)

AGENCY _____

FACILITY # _____ FACILITY ADDRESS _____

FACILITY NAME _____

INDICATE THE APPROPRIATE SERVICE OBJECTIVES TO BE ACHIEVED UNDER
THE CONTRACT DURING FY'97.

1. TOTAL AGENCY SLOTS _____
2. CODAAP FUNDED SLOTS _____ 3. ADMISSIONS _____
4. NUMBER OF CLIENTS TO BE SERVED _____ (equals projected census on
July 1, 1996 plus admissions on Line 3)
5. CLIENT VISITS, METHADONE DISPENSING _____
6. INDIVIDUAL COUNSELING HOURS _____
7. GROUP COUNSELING a) staff hours _____
b) _____ client hours _____
8. TOTAL STAFF HOURS, COUNSELING (equals #6 plus #7a) _____
9. TOTAL CLIENT HOURS, COUNSELING (equals #6 plus #7b) _____
10. SUPPORT SERVICE INTERVENTIONS: staff hours _____
11. NUMBER OF DIRECT SERVICE
HOURS TO BE PROVIDED BY CASE
MANAGERS _____
12. NUMBER OF INDIRECT SERVICE HOURS TO BE PROVIDED BY CASE
MANAGERS _____
13. NUMBER OF SERVICE HOURS TO BE PROVIDED TO CHILDREN _____
14. NUMBER OF PHYSICAL/PSYCHIATRIC EXAMS _____
15. NUMBER OF FULL TIME COUNSELOR EQUIVALENTS _____
16. NUMBER OF FULL TIME CASE MANAGER EQUIVALENTS _____

DATE SUBMITTED _____ SUBMITTED BY _____
(signature)

NAME AND TITLE _____
(name and title typed)

EFFECTIVE DATE OF CHANGE _____
(use only for the date of a revision during the Fiscal Year)

APPROVED BY _____
(Assistant Health Commissioner for CODAAP)

FY'97 CODAAP SERVICE OBJECTIVES INSTRUCTIONS FOR INPATIENT

AGENCY NAME: Enter the Corporate name shown at the top of the Allocation Sheet.

FACILITY: Enter the six digit identification number assigned to the facility by ODAP's licensing division.

FACILITY ADDRESS: Enter the facility(ies) street address(es).

FACILITY NAME: Enter the name used to identify the facility. This should be the same as the Facility Name on the Allocation Sheet across from the funding amount.

1. **TOTAL AGENCY SLOTS:** Enter the total number of slots (static capacity) funded at this facility regardless of funding source.
2. **CODAAP FUNDED SLOTS:** Enter the number of slots (static capacity) funded by the CODAAP allocation at this facility.
3. **ADMISSIONS.**, Enter the projected number of persons to be admitted to the facility during the funding period.
4. **NUMBER OF CLIENTS TO BE SERVED:** Enter the projected number of clients to be served during the funding period. This equals the projected census on July 1, 1996, plus projected admissions (line 3).
5. **TOTAL CLIENT DAYS IN ACTUAL ATTENDANCE:** Enter the projected total number client days during the funding period. This should equal 85-100% of the number of slots multiplied by the number of days the facility operates during the year.
6. **AVERAGE LENGTH OF STAY (calendar days):** Enter the projected average length of stay per client for the funding period. This number equals the total client days on line 5 divided by the total clients to be served on line 4.
7. **COST PER DAY:** This is the FY'97 total cost of the facility (from the budget) divided by Total Client Days on line 5.
8. **INDIVIDUAL COUNSELING HOURS:** Enter the projected number of individual counseling hours to be provided by the facility during the funding period.
9. **GROUP COUNSELING:**
 - a) **Staff Hours:** Enter the projected number of hours to be spent by counseling staff members in the provision of group counseling services to active clients enrolled in the facility during the funding period.

Exhibit 2 (Cont.)

- b) Client Hours: Enter the projected total number of group counseling client hours to be provided during the funding period. This equals line 9a multiplied by the projected average group size.
10. TOTAL STAFF HOURS, COUNSELING: Enter the sum of the entries on lines 8 and 9a to obtain the projected total direct service staff hours to be provided during the funding period.

NOTE: THIS NUMBER SHOULD REFLECT A TOTAL OF 924 HOURS PER FULL TIME COUNSELOR EQUIVALENT AS ENTERED ON LINE 17. REMEMBER, WHAT IS BEING ASKED FOR HERE ARE SPECIFIC HOURS RELATIVE ONLY TO COUNSELING. ADDITIONAL SERVICE HOURS PROVIDED BY STAFF MAY BE PROJECTED ON LINE 12, ENTITLED "SUPPORT SERVICE INTERVENTIONS."

11. TOTAL CLIENT HOURS, COUNSELING: Enter the sum of the entries on lines 8 and 9b to obtain the projected total number of client hours to be provided during the funding period.
12. SUPPORT SERVICE INTERVENTIONS: Indicate the projected number of staff hours n support service interventions to be provided to clients by counseling staff during their length of stay. These interventions should not be confused with counseling service hours. They should include but not be limited to the following areas and not include service hours provided by agency case managers:

a) legal	b) medical	c) vocational
d) educational	e) recreational	f) family
g) housing	h) mental health	i) welfare

13. NUMBER OF DIRECT SERVICE HOURS PROVIDED BY CASE MANAGERS: Indicate the projected number of face to face service hours between case manager and clients to be provided during the funding period.

Only information effecting Case Managers directly hired by the agency should be included in these sections.

14. NUMBER OF INDIRECT SERVICE HOURS PROVIDED BY CASE MANAGERS: Indicate the projected number of non-direct service hours (i.e. phone calls to Welfare, CJS, meetings with housing providers, etc.) to be provided by Case Managers during the funding period.
15. NUMBER OF SERVICE HOURS PROVIDED TO CHILDREN: Indicate the number of direct and indirect staff service hours to be provided to children of clients enrolled/living at your program during the funding period.

15. PHYSICAL/PSYCHIATRIC EXAMS: Enter the number of projected physical/psychiatric exams to be provided to clients at your facility during the funding period.

Exhibit 2 (Cont.)

17. **NUMBER OF FULL TIME COUNSELOR EOUIVALENTS:** Enter the number of full time counselor equivalents projected for the funding period. A full time counselor equivalent (FTE) is an employee working a minimum of 35 hours per week providing individual and/or group counseling at the facility. This number is determined by indicating the appropriate number of counselor equivalents reflected on the Personnel Roster of the program funded budget form. If a supervisor or administrative staff member is also providing direct counseling to clients, that portion of such staff person's time spent in counseling should also be included in the total weekly hours to be provided by counselors to the number of counseling hours to be provided by administrative, supervisory, or other staff. Divide this sum by the number of hours in the normal work week of full time staff.
18. **NUMBER OF FULL TIME CASE MANAGER EOUIVALENTS:** Enter the number of full time case managers equivalents projected for the funding period. A full time case manager equivalent (FTE) is an employee working a minimum of 35 hours per week providing case management services at the facility. This number should be obtained by adding the appropriate number of case manager equivalents reflected on the Personnel Roster of the program's budget forms. If a supervisor or administrative staff is also providing case management to clients, that portion of such staff person's time should also be included in the total projection. The calculation of FTE's is also best done by adding the total weekly hours to be provided by case managers to the number of case management hours to be provided by administrative, supervisory, or other staff, and dividing this sum by the number of hours in the normal work week of full time staff of the facility.

DATE SUBMITTED: Enter the actual date the form is submitted to CODAAP.

SUBMITTED BY: The person responsible for preparing the facility information included on this form (i.e., the facility Director) should sign here.

NAME AND TITLE: Type the name and title of the person who signs this form for the facility.

EFFECTIVE DATE OF CHANGE: Use this line only for a service objective revision during the fiscal year.

APPROVED BY: Leave this blank. Final accepted Service Objectives Forms will be signed by the Assistant Health Commissioner required to achieve the levels of services indicated on the approved Service Objectives Form.

FY'97 CODAAP SERVICE OBJECTIVES PROJECTION FORM INPATIENT
(SEE INSTRUCTIONS BEFORE ATTEMPTING TO COMPLETE THIS FORM)

AGENCY: _____

FACILITY #: _____ **FACILITY ADDRESS:** _____

FACILITY NAME: _____

INDICATE THE APPROPRIATE SERVICE OBJECTIVES TO BE ACHIEVED UNDER THE CONTRACT DURING FY'97.

1. TOTAL AGENCY SLOTS _____
2. CODAAP FUNDED SLOTS _____
3. ADMISSIONS _____
4. NUMBER OF CLIENTS TO BE SERVED _____
(equals projected census on 7/1/96 plus admissions on line 3)
5. TOTAL CLIENT DAYS IN ACTUAL ATTENDANCE _____
(should be 85-100% of the # of slots times the # of days the facility operates from 7/1/96 - 6/30/97)
6. AVERAGE LENGTH OF STAY (calendar days) _____
(equals line 5 divided by line 4)
7. COST PER DAY (total cost divided by line 5) _____
8. INDIVIDUAL COUNSELING HOURS _____
9. GROUP COUNSELING a) STAFF HOURS _____
b) CLIENT HOURS _____
10. TOTAL STAFF HOURS, COUNSELING (equals line 8 + line 9a) _____
11. TOTAL CLIENT HOURS, COUNSELING (equals line 8 + line 9b) _____
12. SUPPORT SERVICE INTERVENTIONS: staff hours _____
13. NUMBER OF DIRECT SERVICE HOURS TO BE PROVIDED BY CASE MANAGERS _____
14. NUMBER OF INDIRECT SERVICE HOURS TO BE PROVIDED BY CASE MANAGERS _____
15. NUMBER OF SERVICE HOURS TO BE PROVIDED TO CHILDREN _____
16. NUMBER OF PHYSICAL/PSYCHIATRIC EXAMS _____
17. NUMBER OF FULL TIME COUNSELOR EQUIVALENTS _____
18. NUMBER OF FULL TIME CASE MANAGER EQUIVALENTS _____

DATE SUBMITTED _____ SUBMITTED BY: _____
(Signature)

Effective Date of Change _____ Name and Title (typed) _____

Approved by: _____

FY'97 CODAAP SERVICE OBJECTIVES PROJECTIONS
STEP-DOWN OR RECOVERY HOUSING

AGENCY: _____

ADDRESS OF HOUSING SITE: _____

1. NUMBER OF SLOTS: _____
2. PROJECTED CENSUS AS OF JUNE 30, 1996: _____
3. PROJECTED NUMBER OF NEW ADMISSIONS FROM 7/1/96 TO 6/30/97: _____
4. NUMBER OF DIFFERENT CLIENTS TO BE SERVED (LINE 2 PLUS LINE 3): _____
5. NUMBER OF CLIENT DAYS IN RESIDENCE: (SHOULD BE A MINIMUM OF .85 MULTIPLIED BY THE NUMBER OF SLOTS MULTIPLIED BY 365 DAYS. THIS FIGURE MUST BE THE SAME AS THE CLIENT DAYS ON THE BUDGET) _____
6. NUMBER OF ON SITE MEETINGS DEVOTED TO RECOVERY ISSUES PER WEEK: _____
7. NUMBER OF OFF-SITE RECOVERY MEETINGS PER CLIENT PER WEEK: _____
(Do not include treatment appointments.)

DATE SUBMITTED: _____

SIGNATURE OF EXECUTIVE DIRECTOR: _____

NAME AND TITLE: _____
(name and title typed)

EFFECTIVE DATE OF CHANGE: _____
(use only for the date of a revision during the Fiscal Year)

APPROVED BY: _____
(Assistant Health Commissioner for CODAAP)

**FY'97 CODAAP SERVICE OBJECTIVES INSTRUCTIONS FOR SHELTERS
AND TRANSITIONAL LIVING FACILITIES**

AGENCY NAME: Enter the Corporate name shown at the top of the Allocation Sheet.

FACILITY NAME: Enter the name used to identify the facility. This should be the same as the Facility Name on the Allocation Sheet across from the funding amount.

FACILITY ADDRESS: Enter the facility street address.

FACILITY: If your facility is licensed, enter the six digit identification number assigned to the facility by the State Health Department's licensing division.

1. **CODAAP FUNDED BLOTS:** Enter the number of slots (static capacity) funded by this allocation.
2. **TOTAL FACILITY SLOTS:** Enter the total number of funded slots in this facility by all sources.
3. **ADMISSIONS:** Enter the total projected number of persons to be admitted to the facility during FY'97.
4. **NUMBER OF CLIENTS TO BE SERVED:** Enter the total projected number of clients to be served during FY'97. This equals the admissions (line #3) plus the projected census on July 1,1996.
5. **NUMBER OF CLIENTS RECEIVING D/A TREATMENT SERVICES OFF SITE:** Enter the projected number of persons living in your facility who will be enrolled in an off-site licensed drug and alcohol treatment program during the funding period.
6. **TOTAL HOURS DAYS IN D/A TREATMENT:** Enter the projected number of hours that clients from your facility will attend treatment off-site during the funding period.

DATE SUBMITTED: Enter the actual date the form is submitted to CODAAP.

SUBMITTED BY: The person responsible for preparing the facility information included on this form (i.e. the facility Director) should sign here.

NAME AND TITLE: Type the name and title of the person who signs this form for the facility.

EFFECTIVE DATE OF CHANGE: Use this line only for a Service objectives revisions during the fiscal year.

APPROVED BY: Leave this blank. Final accepted Service Objectives Forms will be signed by the Assistant Health commissioner for CODAAP and appended to your contract. You

will be required to achieve the levels of services indicated on the approved Service Objectives Form.

SERVICE OBJECTIVES FOR CODAAP FUNDED SHELTERS FISCAL YEAR F97

Agency: _____

Facility Name: _____

Facility Address: _____

Facility Number: _____

Activity Code: _____

INDICATE APPROPRIATE SERVICE OBJECTIVES TO BE ACHIEVED UNDER THE CONTRACT DURING FY'97.

1. CODAAP Funded Slots _____
2. Total Facility Slots _____
3. Admissions _____
4. Number of Clients To Be Served _____
5. Number of Clients Receiving D/A Treatment Services Off Site _____
6. Total Client Hours in treatment off-site. _____

Date Submitted _____ Submitted By _____
(Signature)

Name and title of signer (typed) _____

Effective Date of Change _____
(use only for amendment of a contract in place)

Approved By: _____
Assistant Health Commissioner for CODAAP Date _____

FY'97 CODAAP SERVICE OBJECTIVES INSTRUCTIONS FOR PREVENTION

AGENCY NAME: Enter the Corporate name shown at the top of the Allocation Sheet.

FACILITY # Enter the six digit identification number assigned to the facility by ODAP's licensing division.

FACILITY/ACTIVITY NAME: Enter the name used to identify the program component (e.g. High School Program). This should be the same as the Facility Name on the Allocation Sheet across from the funding amount.

SCHOOL SETTING: Prevention services provided in the school setting to students, parents, and/or school staff. Presentation numbers must be reported by grade level as indicated on the form.

LARGE GROUP PRESENTATIONS (20 PERSONS OR MORE): Enter the appropriate number in each column for presentations to be provided to groups of 20 persons or more during the funding period.

SMALL GROUP PRESENTATIONS (2 TO 19 PERSONS): Enter the appropriate numbers in each column for presentations to be provided to groups of 2 to 19 persons during the funding period.

INDIVIDUAL CONTACTS: Enter the appropriate numbers in each column for individual prevention services contacts or consultations with school staff, students, or parents to be provided during the funding period.

PROM/GRADUATION/YTSC PRESENTATIONS (20 PERSONS OR MORE): Enter the appropriate numbers in each column for prom/graduation presentations to be made in high schools during the funding period.

FAMILY CONSULTATIONS: Enter the appropriate numbers in each column for conferences with parents or other family members regarding students served by prevention specialists.

TOTAL: **SCHOOL SETTING:** Enter the sums of the columns for School Setting.

(continued)

Exhibit 4 (Cont.)

COMMUNITY SETTING: Prevention services are provided in the community to adults or children. Services may be provided to, and/or in conjunction with, community organizations or individuals in order to increase the community's knowledge and awareness of substance use issues, encourage community initiatives, or promote community change or control directed toward reducing substance abuse. Presentation numbers must be reported by age groups as indicated on the form.

LARGE GROUP PRESENTATIONS (20 PERSONS OR MORE): Enter the appropriate numbers in each column for presentations to be provided in community settings to groups of 20 persons or more during the funding period.

SMALL GROUP PRESENTATIONS (2 TO 19 PERSONS): Enter the appropriate numbers in each column for presentations to be provided to groups of 2 to 19 persons during the funding period.

INDIVIDUAL CONTACTS: Enter the appropriate numbers in each column for individual community members to be provided during the funding period.

COMMUNITY OUTREACH PRESENTATION: Enter the appropriate number of presentation made to established community groups (as distinct from ad hoc community groups) for the purpose of coordinating efforts to address common issues.

TOTAL: COMMUNITY SETTING: Enter the sums of the columns in the Community Setting section.

GRAND TOTAL: For each column add the amount on the TOTAL: SCHOOL SETTING line to the amount on the TOTAL: COMMUNITY SETTING line.

COLUMN DEFINITIONS

NUMBER OF PRESENTATIONS/SESSIONS: Enter the total number of presentations or sessions to be made by the Program's staff during the funding period.

STAFF HOURS IN DIRECT PRESENTATION SESSIONS: Enter the total number of staff hours in direct presentations/sessions during the funding period. This should NOT include preparation time.

NOTE: The GRAND TOTAL of this column should reflect a minimum of 770 hours per Full Time Prevention Specialist Equivalent in 10 month program or 924 hours in 12 month program.

(continued)

Exhibit 4 (Cont.)

UNDUPLICATED INDIVIDUALS: Enter the total number of unduplicated (unique) individuals to be provided services during the funding period.

TOTAL ATTENDANCE: Enter the cumulative attendance of individuals to be served during the funding period.

NOTE:The GRAND TOTAL for each column consists of the sum of the School Setting and the Community Setting Totals. The service numbers for prom/graduation programs and YTSC activities are to be INCLUDED in the respective School Setting Total, Community Setting Total, and Grand Total.

Number of Referrals to be Made: Enter the total number of students to be referred to other human services providers during the funding period. D//A treatment and on the appropriate line.

NUMBER OF FULL TIME PREVENTION SPECIALIST EQUIVALENTS: Enter the number of full time Prevention specialist equivalents projected for the funding period. A full time Prevention specialist equivalent (FTE) is an employee working a minimum of 35 hours per week providing prevention/early intervention services. This number should be obtained by adding the appropriate number of counselor equivalents reflected on the Personnel Roster of the program funded budget form. If a supervisor or administrative staff member is also providing prevention/intervention services, that portion of such staff person's time spent in providing direct prevention/intervention services should also be included in the total projection. The calculation of FTE's is best done by adding the total weekly hours to be provided by Prevention Specialists to the number of prevention service hours to be provided by administrative, supervisory, or other staff, and dividing this sum by the number of hours in the normal work week of full time service staff.

DATE SUBMITTED: Enter the actual date the form is submitted to CODAAP.

SUBMITTED BY: The person responsible for preparing the facility information included on this form (i.e. the facility Director) should sign here.

NAME AND TITLE OF SIGNER: Type the name and title of the person who signs this form for the facility.

EFFECTIVE DATE OF CHANGE: Use this line only for a Service objectives revision during the fiscal year.

APPROVED BY: Leave this blank. Final accepted Service Objectives Forms will be signed by the Assistant Health Commissioner for CODAAP and appended to your contract. You

will be required to achieve the levels of services indicated on the approved Service Objectives Form.

Exhibit 4A

CODAAP SERVICE OBJECTIVES FORM FOR PREVENTION - FY/97

AGENCY/FACILITY _____ FACILITY# _____

<u>School Setting</u>	Number of Presentations/Sessions				Staff Hours in Direct Service	Unduplicated Individuals	Total Attendance
	K-5	6-8	9-12	Adults			
Large group presentations (20 persons or more)							
Small group presentations (2 to 19 persons)							
<u>Individual Contacts</u>							
Prom/graduation/Y TSC presentations (20 persons or more)							
Family Consultants							
Total: School Setting							
<u>Community Setting</u>	<10	11-13	14-17	Adults			
Large group presentations (20 persons or more)							
Small group presentations (2 to 19 persons)							
Individual Contacts							
Community Outreach Presentations							
Total: Community Setting							
Grand Total							

Number of referrals made: D/A Treatment _____ Other services _____

Number of full-time prevention specialist equivalents _____

Submitted by: _____ Date submitted _____
(Signature)

Name and title of signer: _____
(Typed)

Effective date of change: _____

Approved by: _____ Assistant Health Commissioner for CODAAP

FY 97 CODAAP SERVICE OBJECTIVES INSTRUCTIONS FOR INTERVENTION

AGENCY NAME: Enter the Corporate name shown at the top of the Allocation Sheet.

FACILITY: Enter the six digit identification number assigned to the facility by ODAP's licensing division.

FACILITY NAME: Enter the name used to identify the facility. This should be the same as the Facility Name on the Allocation Sheet across from the funding amount.

FACILITY ADDRESS: Enter the facility street address.

ACTIVITY CODE: Enter the appropriate activity code, i.e. 71 or 73.

1. **INDIVIDUAL COUNSELING HOURS:** Enter the projected number of individual counseling hours to be provided by the facility during the funding period.

2. **GROUP COUNSELING:**

a) **STAFF HOURS** - Enter the projected number of hours to be spent by counseling staff members in the provision of group counseling services to active clients enrolled in the facility during the funding period.

b) **CLIENT HOURS** - Enter the projected total number of group counseling client hours to be provided during the funding period. This equals line 2a multiplied by the projected average group size.

3. **INFORMATION/EDUCATIONAL GROUP**

a) **STAFF HOURS** - Enter the projected number of hours to be spent by the clinical staff in the provision of information or education to clients during the funding period. These services include substance abuse information regarding other services needed by the clients and education on topics pertinent to the needs of the program's target population.

b) **CLIENT HOURS** - Enter the projected number of hours of substance abuse educational and information services to be provided to clients during the funding period. This line equals line 3a multiplied by the average group size.

4. **TOTAL STAFF HOURS:** Enter the sum of the entries on lines 1 and 2a and 3a to obtain the projected total direct service staff hours to be provided during the funding period.

NOTE: THIS NUMBER SHOULD REFLECT A MINIMUM OF 924 HOURS PER FULL TIME COUNSELOR EQUIVALENT AS ENTERED ON LINE 8.

Exhibit 5 (Cont.)

5. **TOTAL CLIENT HOURS:** Enter the sum of the entries on lines 1, 2b, and 3b to obtain the projected total number of client hours to be provided during the funding period.
6. **CLIENTS SCREENED:**
- a) **IN PERSON** - Enter the projected number of in person client screenings for the funding period.
 - b) **TELEPHONE ONLY** - Enter the projected number of clients to be screened by telephone only for the funding period.
 - b) **TOTAL CLIENTS SCREENED:** Sum of lines 6a and 6b.
7. **CLIENTS REFERRED:**
- a) **IN PERSON** - Enter the projected number of in person client referrals during the funding period.
 - b) **TELEPHONE ONLY** - Enter the projected number of clients to be referred by telephone only during the funding period.
 - c) **TOTAL CLIENTS REFERRED:** Sum of lines 7a and 7b.
8. **NUMBER OF FULL TIME DIRECT CLIENT SERVICE STAFF EQUIVALENTS:**
Enter the number of full time direct client service staff equivalents projected for the funding period. A full time direct client service staff equivalent is an employee working a minimum of 35 hours per week providing direct client services at the facility. This includes but is not limited to, individual and group counseling, and information and educational services. This number of such staff equivalents to be entered on line 8 should be obtained by adding the appropriate number of direct client service staff equivalents reflected on the Personnel Roster of the program funded budget form. If a supervisor or administrative staff member is also providing direct client services, that portion of such staff person's time spent in direct client services should also be included in the total projection. The calculation is best done by adding the total weekly hours to be provided by the appropriate staff to the number of appropriate hours to be provided by administrative, supervisory, or other staff, and dividing this sum by the number of hours in the normal work week of full time staff of the facility.

DATE SUBMITTED: Enter the actual date the form is submitted to CODAAP.

SUBMITTED BY: The person responsible for preparing the facility information included on this form (i.e. the facility Director) should sign here.

NAME AND TITLE: Type the name and title of the person who signs this form for the facility.

EFFECTIVE DATE OF CHANGE: Use this line only for a Service objectives revision during the
fiscal Year.

Exhibit 5 (Cont.)

APPROVED BY: Leave this blank. Final accepted Service Objectives Forms will be signed by the Assistant Health Commissioner for CODAAP and appended to your contract. You will be required to achieve the levels of services indicated on the approved Service Objectives Form.

FY'97 CODAAP SERVICE OBJECTIVES PROJECTIONS INTERVENTION (SEE INSTRUCTIONS BEFORE ATTEMPTING TO COMPLETE THIS FORM)

AGENCY _____

FACILITY # _____ FACILITY ADDRESS _____

FACILITY NAME _____

ACTIVITY CODE _____

INDICATE THE APPROPRIATE SERVICE OBJECTIVES TO BE ACHIEVED UNDER THE CONTRACT DURING FY'97.

NOTE: Agencies providing intervention services under code 71 or 73 should fill in all sections of this form. Where service information does not apply to a program, enter a zero on those lines.

1. INDIVIDUAL COUNSELING HOURS _____

2. GROUP COUNSELING a) staff hours _____
b) client hours _____

3. INFORMATION/EDUCATIONAL GROUPS a) staff hours _____
b) client hours _____

4. TOTAL STAFF HOURS, (equals line 1 plus 2a plus 3a) _____

5. TOTAL CLIENT HOURS, (equals line 1 plus 2b plus 3b) _____

6. CLIENTS SCREENED
a) In person _____
b) Telephone only _____
c) Total Clients Screened (6a + 6b) _____

7. CLIENTS REFERRED
a) In person _____
b) Telephone only _____
c) Total clients referred (7a + 7b) _____

8. NUMBER OF FULL TIME DIRECT CLIENT SERVICE STAFF EQUIVALENTS _____

DATE SUBMITTED _____ SUBMITTED BY _____
(signature)

NAME AND TITLE _____
(name and title typed)

EFFECTIVE DATE OF CHANGE _____
(use only for the date of a revision during the Fiscal Year)

APPROVED BY _____
(Assistant Health commissioner for CODAAP)

FY' 97 CODAAP SERVICE OBJECTIVES PROJECTIONS

NON-HOSPITAL EXPERIMENTAL

AGENCY: IMPACT SERVICES CORPORATION

FACILITY #: 860087 FACILITY ADDRESS: 124 E. INDIANA AVENUE

FACILITY NAME: IMPACT SERVICES

ACTIVITY: CLIENT TRAINING ACTIVITY CODE: 53

INDICATE THE APPROPRIATE SERVICE OBJECTIVES TO BE ACHIEVED UNDER THE CONTRACT DURING FY' 97.

- 1. NUMBER OF CLIENTS TO BE SERVED _____
- 1. ADMISSIONS _____
- 1. CLIENT TRAINING HOURS _____
- 1. NUMBER OF HOURS OF TRAINING PROVIDED BY IMPACT SERVICES STAFF

- 1. NUMBER OF CLIENTS COMPLETING TRAINING _____ (number of clients discharged with training completed in FY' 97)
- 1. NUMBER OF FULL TIME CLIENT TRAINING STAFF EQUIVALENTS _____

DATE SUBMITTED _____ SUBMITTED BY _____
(signature)

NAME AND TITLE _____
(name and title typed)

EFFECTIVE DATE OF CHANGE _____
(use only for the date of a revision during the Fiscal Year)

APPROVED BY _____
(Assistant Health Commissioner for CODAAP)

This Exhibit should be obtained from either the subrecipient or the Department of Health.

This Exhibit should be obtained from either the subrecipient or the Department of Health.