

**CITY OF PHILADELPHIA  
SUBRECIPIENT AUDIT GUIDE**

**Issued By:  
Office of the Director of Finance**

# CITY OF PHILADELPHIA SUBRECIPIENT AUDIT GUIDE

Highlights of Changes

June 1997

## SECTION 100

- The 1997 Audit Guide will apply if total federal financial assistance expended by a subrecipient through City of Philadelphia contract(s) (either directly from the City or indirectly through another City subrecipient) is \$300,000 or more during the subrecipients fiscal year.
- The \$300,000 is not the total assistance provided under City of Philadelphia contract(s) but only the federal portion.
- The City or any of the Departments in the City have the right to require an audit or agreed-upon procedures to be performed below the \$300,000 level. This requirement will be communicated to the provider agency.
- The new audit requirements are effective for provider agencies in the fiscal years beginning on or after July 1, 1996.
- Notification of Engagement of Auditor Form needs to be submitted by the organization's year-end and not 60 days prior to the year-end as previously required (Section 103.17).
- Name, address, telephone and fax number changes for certain City Departments (Sections 104.03 and 105.01).
- Office of Housing and Community Development needs to receive additional copies of report for certain CFDA programs funded through other City Departments (Section 103.03 - Note No.(2))

## SECTION 200

- Addition of following technical references:
- AICPA SAS No. 82 - Consideration of Fraud in a Financial Statement Audit (Section 202.06)
- OMB A-133 (Revised June 24, 1997) (Section 204.07)
- OMB A-133 Compliance Supplement - Provisional 6/97 (Section 204.10)

## SECTION 300

- In accordance with OMB Circular A-133 (Revised June 24, 1997) auditors are to utilize a risk-based approach to determine which Federal programs are major programs. For the purposes of this Audit Guide only the Federal portion of a City of Philadelphia contract award is to be considered in the determination of major programs.
- Risk-based approach is to be utilized on auditing the Federal funds passed through a City of Philadelphia contract (Section 305.02).
- New OMB A-133 Compliance Supplement (Provisional 6/97) is required to be utilized in testing of major programs (Section 305.05 to 305.08).
- City of Philadelphia Compliance Audit Requirements (Section 306.11) changed regarding auditing/reporting, as follows:
- For certain City of Philadelphia Department's a supplemental financial schedule will be required when the total assistance provided by the City for a contract is \$300,000 or more. This is the total amount of assistance expended, whether Federal, State or City funded.

- In most instances the supplemental financial schedules will require an auditor's opinion in accordance with the City of Philadelphia, Subrecipient Audit Guide. In some instances the supplemental financial schedules will only require an agreed-upon procedures report on whether the amounts reflected in the schedule are in agreement with the agency's books of account.

- The auditor is to report questioned costs in the schedule of findings and questioned costs for known questioned costs which are greater than \$10,000 for a type of compliance requirement for a major program or where an audited supplemental schedule is required. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor shall also report known questioned costs when likely questioned costs are greater than \$10,000 for a type of compliance requirement for a major program or when an audited supplemental schedule is required (Section 308.05).

- Requirements of revised OMB A-133 regarding follow-up of prior audit findings has been added to the Audit Guide. This new requirement necessities work by the organization on the current status of prior audit findings (Section 311).

#### **SECTION 400**

- To be provided at a later date.

#### **SECTION 500**

- Changed program audit requirement to the organization's fiscal year rather than the contract period (Section 502.01).

- Reporting requirements to be provided at a later date.

#### **SECTION 1000**

- Addition of Micro-Enterprise Assistance Program to Sections 1110 and 1130.

- Requirement of supplemental financial schedules only when the total expenditures for a City contract is \$300,000 or more (Section 1150.01).

- Agreed-upon procedures report when supplemental schedules are required (Section 1150.01).

#### **SECTION 2000**

- Change in CFDA numbers (Section 2120.01)

- Requirement of supplemental financial schedules only when the total expenditures for a City contract is \$300,000 or more (Section 2150.01).

- Auditor's opinion will be required on the supplemental schedules (Section 2150.01).

#### **SECTION 3000**

- Certain program types were eliminated from this section since they are no longer pertinent.

#### **SECTION 4000**

- Changes in CFDA numbers (Section 4120.01).

- Reference to OMB Circular Compliance Supplement (Provisional 6/97) and Catalog of Federal Domestic Assistance (CFDA) as sources for program and financial compliance procedures (Sections 4130 and 4140).

- Requirement of supplemental financial schedules only when the total expenditures for a City contract is \$300,000 or more (Section 4150.01).

- Agreed-upon procedures report when supplemental schedules are required (Section 4150.01).

## **SECTION 5000**

- Addition of Innovative Homeless Initiatives Demonstration Project Program to Sections 5110, 5120 and 5130.

## **SECTION 6000**

### **AACO Programs:**

- Change of program name of Support Services to Aids Care Services.
- Addition of HIV Prevention: Education and Risk Reduction Program to Sections 6130.12 to 6130.15.
- Requirement of supplemental financial schedules only when the total expenditures for a City contract is \$300,000 or more (Section 6150.01).
- Auditor's opinion will be required on the supplemental schedules (Section 6150.01).
- New Exhibits

### **CODAAP Programs:**

- Requirement of supplemental financial schedules only when the total expenditures for a City contract is \$300,000 or more (Section 6250.01).
- New Exhibits

### **OMH/MR Programs:**

- Changes to CFDA Numbers (Section 6320.01).
- Addition of compliance procedures on Early Intervention Program (Section 6330.50).
- Changes to financial auditing procedures relating to:
  - Third party revenue (Section 6340.15)
  - Retained revenue (Section 6340.17)
- Addition of the line item "Retained Revenue Allowance" to the Schedule of Adjustments on Program Activity Invoice Summary (Section 6350.04).
- Requirement of supplemental financial schedules only when the total expenditures for a City contract is \$300,000 or more (Section 6350.01).
- Auditor's opinion will be required on the supplemental schedules (Section 6350.01).

### **Office of Maternal and Child Health:**

- Changes to various program descriptions.
- Change in CFDA Numbers (Section 6420.01).
- Requirement of supplemental financial schedules only when the total expenditures for a City contract is \$300,000 or more (Section 6450.01).
- Auditor's opinion will be required on the supplemental schedules (Section 6450.01).
- New Exhibits

### **Division of Disease Control:**

- No changes.

### **Appendix:**

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- B Office of Management and Budget Circular A-133
- C City of Philadelphia - Contract Cost Principles and Guidelines

(Rev. 6/97)

## **SECTION 6000**

### **DEPARTMENT OF PUBLIC HEALTH**

#### **Section 6001 - General Information**

- .01 The Philadelphia Department of Public Health provides a broad range of services. It has grown since its inception during the nineteenth century to a multi-faceted agency which serves thousands of Philadelphians each year.
- .02 The Department of Public Health serves the public through many roles. It offers ambulatory care services, health promotion and education.

## **SECTION 6100 - AIDS ACTIVITIES COORDINATING OFFICE**

#### **Section 6101 - General Information**

- .01 The mission of the AIDS Activities Coordinating Office (AACO) is to stop the transmission of the Human Immunodeficiency Virus (HIV) in Philadelphia through education and prevention activities and to provide services to people with AIDS and to individuals with HIV infection related conditions. The Office is charged with coordination of all City of Philadelphia activities related to AIDS.
- .02 The AIDS Activities Coordinating Office includes four major divisions. These are: Medical Affairs, Policy and Planning; AIDS Prevention and Education Services; AIDS Agency Services; and AIDS Program Administration. Of these four divisions, the two with responsibility for the development and monitoring of contract service activities are AIDS Agency Services and AIDS Program Administration. Program development and monitoring are the responsibility of the former while contract and fiscal management rests with the latter.

#### **Section 6110 - Program Descriptions and Operations**

- .01 Some of the services provided by AACO include the following:

##### **a. AIDS Care Services:**

Support services consist of those services that are provided directly to those individuals who are HIV positive and/or have been diagnosed as having Acquired Immunodeficiency Syndrome (AIDS). In addition, care services are intended to provide support for family members and the loved ones of those who are infected with the Human Immunodeficiency Virus (HIV). Services usually consist of helping the individual in maintaining their self worth, independence, and human dignity while living with AIDS.

AIDS case management services consists of performing a needs assessment and developing, implementing, and monitoring a service/care plan as well as arranging for or referring a client to needed services. Such services, to which clients may be referred or which are arranged for clients, can be any services needed for activities of daily living, caring for HIV/AIDS infected individuals, and alleviation of psychological and social consequences of infection. Case management services require a thorough needs assessment and the development and monitoring of a formal services plan for the client.

##### **b. Education:**

Education consists of activities aimed at changing knowledge, attitudes, and behaviors of individuals or groups for the purpose of motivating them to avoid contracting or transmitting HIV or alleviating anxiety about transmission and effects of the virus. Education is further defined as activities geared to increasing knowledge and skills of those who perform services for the HIV infected or their friends, families or significant others. Education activities normally consist of presentations, consultations, training, instruction, outreach, hotline operations, and media efforts.

## Section 6110 (Cont.)

- .02 All agencies under contract with the City of Philadelphia through AACO must submit monthly financial status reports. The purpose of the procedures package is to effectively and efficiently process requests for payment from each contract agency. The package indicated what types of reports were required, information to be included in each report and examples of how each report should look.
- .03 In order for an agency to invoice AACO (City of Philadelphia) for the expenditure of funds allocated through a contract, the submission of a cover letter, an invoice, a monthly budget performance report, and a personnel roster is required. Authorized advance payments must be requested in a letter. Additional information may also be required. Actual requirements for the preceding documents are detailed as follows:
- Invoices may differ in format but must include all of the following:
    - a) date submitted;
    - b) period of service for which invoice is being submitted for;
    - c) contract number;
    - d) contract name;
    - e) current period's expenses (as categorized in the contract budget.)
  - (Exhibit 1) Monthly Budget Performance Reports must accompany each invoice. This report identifies expenditures in the categories listed on the AACO approved line item budget form and must show current month and year-to-date expenses as well as total budget and the total amount remaining for each line item of the budget. Each column (current month, year-to-date, annual budget, budget amount remaining) must be totaled. Revenue offsetting program/contract costs must be indicated and subtracted from total expenses in all columns.
  - (Exhibit 2) Personnel Rosters must also accompany each invoice. Each roster must identify names of personnel being charged to a specific program/contract as well as expenditures for each position title. Columns showing current month and year-to-date expenses as well as total budget and total amount remaining for each position must be included and each column must be totaled.
  - Advance Payments allow for a percentage of the total contract to be paid upon conformation of the contract and must be requested in the form of a letter on Agency/Corporate letterhead. All of the following must be included in each letter:
    - a) contract name;
    - b) contract number;
    - c) signature of authorized corporate official;
    - d) percentage of the contract total requested and the amount.

## Section 6120 - Federal CFDA Numbers/Other Regulations

.01 The following Federal CFDA numbers are applicable to AACO Programs:

<b>Program</b>	<b>CFDA No.</b>
AIDS Surveillance and Seroprevalence Grant	93.118, 93.944
AIDS Prevention Project	93.940
HIV Emergency Relief Grant (Formula) (Ryan White)	93.915
HIV Emergency Relief Grant (Supplemental) (Ryan White)	93.914
HIV Early Intervention Project	93.918
HIV Early Intervention Services	
Network Demonstration Project	93.118

## **Section 6130 - Program Compliance Procedures**

.01 As discussed in Sections 300 and 500 of this Audit Guide, each City of Philadelphia Department program has specific auditing requirements. These requirements are in addition to those areas of audit specified in Sections 300 and 500 of this Guide. The audit requirements listed on the following pages are not all inclusive and do not represent an audit program for conducting a financial and compliance audit of the program(s). The audit requirements listed are presented as highlights of areas of special interest to the Department. Any deficiencies noted as a result of the procedures are to be disclosed in the Schedule of Findings and Questioned Costs.

### **Program Description and Personal Data Questionnaire**

.02 The AIDS Agency Services Unit monitors and evaluates programs and direct services for persons with HIV infection. These services include, but are not limited to, AIDS education, support, case management, housing, and HIV counseling and testing. Epidemiology and miscellaneous service contracts are also the responsibility of this unit. All agencies are required to report to their respective AACO program analyst on the progress of the services being rendered.

.03 Each service is different in nature and requires specific reporting procedures to be followed; however, there are a few reports which AACO requires all contract agencies to submit. These reports include a Position Description and Personal Data Questionnaire (PDPDQ) (Exhibit 3) and monthly statistical and narrative reports. At this time, the PDPDQ is the only standardized form relevant to all AACO contract agencies. Each Agency is required to submit this form to AACO within six months of the contract effective date for all personnel funded by the contract. New staff are required to fill the questionnaires out at the time of their hiring and the agency must submit the forms within thirty (30) days of the hiring date.

.04 Audit procedures are to include a determination that the PDPDQ is on file at the Organization and that the reporting and filing requirements described above have been met

### **Aids Care Services**

.05 AACO has many contracts with agencies whose services are provided directly to those individuals who are HIV positive and/or have been diagnosed as having AIDS. Care services help individuals maintain their self worth, independence and dignity while living with AIDS. Such services include, but are not limited to primary care, dental, skilled nursing, transportation, homemaker services, respite care, case management and other required services. Quarterly narrative reports (see Exhibit 7) must contain specific information. In addition to the reporting requirements, the resultant auditing procedure is also stipulated.

- Skilled nursing agencies are required to submit in their monthly reports statistics reflecting the number of Medicaid waivers completed per month. The auditor should determine, on a test basis, that reports include this information and are in compliance with the contract service provisions.
- Agencies providing homemaker services must include in their monthly reports statistics reflecting the number of clients served each month and the number of hours provided per client per month. Minimum and maximum numbers of clients and hours are provided in the contract service provisions. The auditor should determine, on a test basis, that reports include this information and are in compliance with the provisions.
- Agencies providing transportation services must include statistics reflecting the number of trips taken per month and the number of clients transported per month in each monthly report. As with homemaker services, minimum and maximum numbers of trips to be taken and clients to be transported are provided in the contract service provisions. The auditor should determine, on a test basis, that reports include this information and are in compliance with the provisions.

## **AIDS Care Services**

- .06 AIDS Case Management services consist of thorough assessments of clients' needs and the development and monitoring of a formal services plan for each client. Agencies providing this type of service assign case managers who aid clients with their daily living needs. These needs vary with each client; therefore, documentation of services provided is extremely important.
- .07 AACO's analytical staff must be able to make their programmatic decisions based on monthly reports from provider agencies. These reports are similar in format to other services' monthly reports; however, more specific information is required. Although no standardized forms are available to agencies at the present time, AACO program staff are in the process of developing a standardized statistical form to be included in future contracts. Nonetheless, statistical information regarding number of clients seen per month, per case manager, is important to AACO.
- .08 Currently, all case management service providers are required to keep a file on each client served. Each client case record file should contain the following list of documents:
  - Assessment Form
  - Data Entry Form
  - Case Management
  - Client Agreement Form
  - Authorization to obtain release of information.
  - Surveillance letters:
    - (a) To physician
    - (b) To AACO Surveillance Unit.
  - Agency Consent Form
  - Buddy Agreement Form
  - Buddy Program Work Sheet
  - Treatment Care Plan
  - Physician Release Form
  - Case Management Activities Log
  - Progress Notes Form
- .09 The auditor should determine on a test basis that:
  - The statistical information reported by the organization to AACO on the monthly statistical reports are traceable to, and in agreement with, supporting records.
  - Client files contain the information required under Section 6130.21.

## **Counseling and Testing Services**

- .10 The counseling and testing programs are required to provide AACO with a monthly report (Exhibit 4) which includes various statistical, programmatic, and staffing information.
- .11 The auditor should determine, on a test basis, that the:
  - Statistical information included on the report is traceable to records maintained by the Organization to support the report submitted to AACO. The statistical information needed to be verified by the auditor includes number of individuals pre-tested, number of individuals counseled and not tested, number of individuals tested, and number of individuals post-tested. The source document to be used in verifying the above information is included in Exhibit 4.

## **HIV Prevention: Education and Risk Reduction**

- .12 The education and risk reduction programs are required to provide AACO with a monthly report (Exhibit 5) which includes various statistical, programmatic, and staffing information.
- .13 The auditor should determine, on a test basis that the statistical information included on the report is traceable to records maintained by the organization to support the report(s) submitted to AACO.

## **HIV Prevention: Education and Risk Reduction**

- .14 For hotline services, all calls received must be documented on a hotline call record form (Exhibit 6). This is a standardized form which must be completed by a counselor during each telephone conversation.
- .15 The auditor should determine, on a test basis, that the hotline call record forms are utilized and maintained on file at the organization.

## **AIDS Education**

- .16 Other than the Position Description and Personal Data Questionnaire (PDPDQ) which all providers must submit to AACO, AIDS Education Programs must submit a monthly statistical report with narratives within ten working days after the end of each month. These reports document the various education activities performed by each agency. There are no format requirements; however, each report should include the same information regarding the activities conducted during the report period, projected activities for subsequent periods, problems encountered and how they were solved, and supporting statistical data for quantifiable information.
- .17 Each agency is required to track participant attendance for all presentations, workshops, consultations, trainings, and instructions. Attendance sheets are the responsibility of the agency and may be in whatever format they choose to follow; however, participants' names, instructors'/educators' names, and the date of the activity must be included on the form.
- .18 Before and after each educational activity, the instructor/educator must test the knowledge of each participant. This is done through a standardized test which the agency or AACO has developed. Each test, although very often the same, must be presented as two separate distinguishable tests. The first test should be labeled "Pre-test" and the second test should be labeled "Post-test."
- .19 The monthly statistical/narrative report should include a summary of the above information.
- .20 The auditor should determine, on a test basis, the counseling and testing services, that:
  - Statistical information reported corresponds with supporting documents/records maintained at the Organization.
  - Attendance records are utilized and kept on file for participants attending presentations, workshops, consultations, training and instruction.

## **Section 6140 - Financial Compliance Procedures**

### **Revenues:**

- .01 Program funding is the most common method employed by AACO to fund its provider agencies. This method allows AACO to fund a provider agency's actual eligible expenditures for a provider agency's service(s), offsetting these expenses by anticipated revenues to be received directly by the provider, and establishing the remaining deficit as its authorized level of funding (allocation). Reimbursement is affected on a "last-dollar-in" basis and is based upon actual eligible expenses incurred less actual revenue generated, up to the maximum contract funding.
- .02 Audit procedures should include the following:
  - Does the Agency have a system in place to adequately account for all applicable income received or earned by the agency and that such income was properly reported to AACO.
  - Determine that billings to AACO and reimbursement from AACO are net of other non-AACO revenue.

## Section 6150 - Supplemental Financial Schedules and Reports

.01 The organization's audit report must include the following supplemental financial schedule for each City of Philadelphia contract with \$300,000 or more of expenditures in addition to the financial statements as specified in Sections 400 and 500 of this Audit Guide. A designation has been made for the supplemental schedule required for a "single audit" report (Section 400) on a "program audit" report (Section 500). The auditor will be required to issue an opinion on the Supplemental Schedules listed below as specified in Section 400 of this Audit Guide.

Supplemental Financial Schedule	Section Ref. to Sample Format	Single Audit Report	Program Audit Report
Schedule of Program Expenditures and Program Revenue (1)	6150.02	Yes	No (2)

### Explanatory Notes:

- (1) The schedule must reflect the categorization of expenditures by the AACO budget with the organization.
- (2) The categories of expenditures provided on the program audit financial statement should coincide with the categories of expenditures on the AACO budget.

**Section 6150.02**

**ABC NOT-FOR-PROFIT CORPORATION  
AACO CONTRACT NUMBER XX-XXXX  
STATEMENT OF PROGRAM EXPENDITURES AND PROGRAM REVENUE  
FOR THE YEAR ENDED JUNE 30, 19XX**

**Expenditures**

Personnel:	
Salaries	\$ XXX,XXX
Fringe benefits	<u>XX,XXX</u>
<b>Total personnel expenditures</b>	<b>\$ XXX,XXX</b>
Operating:	
Occupancy	XX,XXX
Renovation	X,XXX
Communications	XXX
Office Supplies	XXX
Education/Program supplies	X,XXX
Travel	X,XXX
Contract Services	X,XXX
Insurance	X,XXX
Condoms	<u>X,XXX</u>
<b>Total operating expenditures</b>	<b>XX,XXX</b>
Equipment:	
Purchase	XX,XXX
Lease/rental	X,XXX
Repairs	<u>X,XXX</u>
<b>Total equipment expenditures</b>	<b>XX,XXX</b>
<b>Total direct expenditures</b>	<b>XXX,XXX</b>
<b>Administration</b>	<b><u>XX,XXX</u></b>
<b>Total expenditures</b>	<b>XXX,XXX</b>
<b>Program Revenue</b>	<b>(X,XXX)</b>
<b>Net AACO funded expenditures</b>	<b>\$ XXX,XXX</b>

**AACO - EXHIBITS  
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EXHIBIT	DESCRIPTION
1	Monthly Budget Performance Report
2	Personnel Roster
3	Position Description and Personal Data Questionnaire
4	Counseling and Testing Package
5	Education and Risk Reduction Package
6	Hotline Call Record Form
7	Aids Care Services/Ryan White Package

## Exhibit 1

### BUDGET STATEMENT AIDS AGENCY XYZ COUNSELING SERVICES (CONTRACT XX-XXXX) AUGUST, 19XX

	August	Year To-Date	Total Budget	Budget Remaining
<b>Expenses</b>				
<b>Personnel:</b>				
Salaries	\$ 18,510	\$ 35,489	\$ 267,000	\$ 231,511
Benefits	2,124	4,072	30,638	26,566
Other	-0-	-0-	300	300
Sub-total personnel	20,634	39,561	297,938	258,377
<b>Operating</b>				
Occupancy	3,045	6,090	36,540	30,450
Renovation	-0-	-0-	-0-	-0-
Communications	1,245	1,900	8,700	6,800
Office Supplies	603	603	2,500	1,897
Education/Program supplies	262	524	1,750	1,226
Travel	174	348	2,784	2,436
Contract Services	-0-	-0-	-0-	-0-
Insurance	85	170	1,025	855
Condoms	150	250	1,500	1,250
Sub-total operating	5,564	9,885	54,799	44,914
<b>Equipment</b>				
Purchase	-0-	-0-	3,000	3,000
Lease/rental	39	78	468	390
Repairs	-0-	-0-	500	500
Sub-total equipment	39	78	3,968	3,890
Subtotal direct	26,237	49,524	356,705	307,181
Administration	933	1,874	13,500	11,626
Sub-total	27,170	51,398	370,205	318,807
Revenue	(500)	(1,000)	(7,121)	6,121)
Grand total	\$ 26,670	\$ 50,398	\$ 363,084	\$ 312,686

**Exhibit 2**

**AIDS AGENCY XYZ  
CONTRACT XX-XXXX**

	August Billing	Cumulative Billings	Budget Per Budget Contract	Remaining
<b>Personnel Service (by position):</b>				
<b>Prog. Coord.</b>				
B. Smith	\$3,333	\$6,666	\$40,000	\$33,334
<b>Counselor</b>				
J. Jones	2,500	5,000	30,000	25,000
<b>Educator</b>				
A. Carter	2,667	5,334	32,000	26,666
<b>Secretary</b>				
M. Cuyler (hired 7/15/XX)	1,625	2,437	19,500	17,063
<b>Educator</b>				
C. Jackson (term. 7/31/XX)	-0-	2,667	32,000	29,333
D. Kelly (hired 8/1/XX)	2,667	2,667	-0-	(2,667)
<b>Counselor</b>				
G. Martin	2,500	5,000	30,000	25,000
<b>Counselor</b>				
F. Berk	2,500	5,000	30,000	25,000
<b>Education</b>				
Vacant	-0-	-0-	32,000	32,000
<b>Phlebotomist</b>				
N. Mill (hired 8/10/XX)	718	718	21,500	20,782
Total	\$ 18,510	\$ 35,489	\$ 267,000	\$ 231,511

**ATTACHMENT C**  
**Exhibit 3**

**Position Description and Personal Data Questionnaire**  
**City of Philadelphia Aids Activities Coordinating Office Personnel Action Plan**

1. Position Number \_\_\_\_\_  
2. Request for personnel action on \_\_\_\_\_  
Existing position \_\_\_\_\_

**New Incumbent - New Position (Explain)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Position (Explain)**

\_\_\_\_\_  
\_\_\_\_\_

**Conversion**

3. Last Name \_\_\_\_\_ First \_\_\_\_\_ Mi \_\_\_\_\_  
4. Agency \_\_\_\_\_  
5. Service, division, unit \_\_\_\_\_  
6. Total working hrs per week in agcy. \_\_\_\_\_  
7. No. working hrs. chgd to county prog. \_\_\_\_\_  
8. Requested "Pap" title \_\_\_\_\_  
9. Usual working title \_\_\_\_\_  
10. Annual salary (for total hrs. worked, #6) \_\_\_\_\_

11. Describe types of work you do during working hours on County Program. Use separate paragraph for each kind of work and explain in detail. List your duties in order of importance, showing estimate of time spent on each duty by percentage, fractions, \_\_\_ days or hours in "Time" column. Special or occasional duties should be last.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Time \_\_\_\_\_

Work Performed \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

(Continue on additional sheets)

12. Name and title of your immediate supervisor \_\_\_\_\_

Are you in a supervisory capacity \_\_Yes\_\_No

13. Give name and title of employees you supervise if five or less, if more than five, give the number under each title.

Name \_\_\_\_\_ Title \_\_\_\_\_

Name \_\_\_\_\_ Title \_\_\_\_\_

Name \_\_\_\_\_ Title \_\_\_\_\_

Name \_\_\_\_\_ Title \_\_\_\_\_

14. Describe your contact with other agencies outside organizations and general public.

\_\_\_\_\_  
\_\_\_\_\_

**ATTACHMENT C**  
**Exhibit 3**

**Position Description and Personal Data Questionnaire**  
**City of Philadelphia Aids Activities Coordinating Office Personnel Action Plan**

**Personal Data**

Home Address \_\_\_\_\_  
Zip \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_  
Date started this position \_\_\_\_\_ Starting salary \_\_\_\_\_

**Education**

Schools (Circle highest grade or year completed)  
College \_\_\_\_\_  
Postgrad/Professional 1 2 3 4 5 6 7 8 9 10 11 12 \_\_\_\_\_ 1 2 3 4 \_\_\_\_\_ 1 2 3 4  
Degree Major/Specialty \_\_\_\_\_

Describe other education or training

\_\_\_\_\_  
\_\_\_\_\_

**Previous employment**

(List related experience. Begin with the most recent employment and work backward)

Title \_\_\_\_\_  
Major duties \_\_\_\_\_  
Employer \_\_\_\_\_  
From (Mo. Yr) \_\_\_\_\_ To (Mo. Yr) \_\_\_\_\_ Last salary \_\_\_\_\_

Title \_\_\_\_\_  
Major duties \_\_\_\_\_  
Employer \_\_\_\_\_  
From (Mo. Yr) \_\_\_\_\_ To (Mo. Yr) \_\_\_\_\_ Last salary \_\_\_\_\_

Title \_\_\_\_\_  
Major duties \_\_\_\_\_  
Employer \_\_\_\_\_  
From (Mo. Yr) \_\_\_\_\_ To (Mo. Yr) \_\_\_\_\_ Last salary \_\_\_\_\_

I hereby certify that the above answers are my own and are accurate and complete.

Employees Signature \_\_\_\_\_ Date \_\_\_\_\_

**STATEMENT OF IMMEDIATE SUPERVISOR**

15. Comment on statements of employee. Indicate any exceptions or additions and what you consider the most important duties of this position.

\_\_\_\_\_  
\_\_\_\_\_

17. Background desirable of a new appointee to fill this position in case of a vacancy. Disregard qualifications present incumbent may happen to have or not have. Training and experience give kind and length  
Signature immediate supervisor \_\_\_\_\_

**STATEMENT OF DEPARTMENT HEAD OR OTHER ADMINISTRATIVE OFFICER**

18. Comment on above statements of employee and supervisor. Indicate any inaccuracies or statement with which you disagree. Also, comment on qualifications suggested by supervisor.

Signature department head/administrative officer \_\_\_\_\_  
Title \_\_\_\_\_ Date \_\_\_\_\_

**Exhibit 4  
Attachment B**

**PATIENT FOLLOW-UP/PARTNER NOTIFICATION FORM**

**Check One:**

Patient Follow-Up \_\_\_\_\_ Partner Notification \_\_\_\_\_  
Date Tested \_\_\_\_\_  
Date Interviewed \_\_\_\_\_

Name: \_\_\_\_\_ Alias/Nickname: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
Work Address/Hangouts: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Marital Status: \_\_\_\_\_  
Work Hours: \_\_\_\_\_ Home Phone #: \_\_\_\_\_ Work Phone#: \_\_\_\_\_  
Exposure Information: \_\_\_\_\_  
\_\_\_\_\_

First: Sex \_\_\_\_\_ Needle Sharing \_\_\_\_\_ Other \_\_\_\_\_  
Last: \_\_\_\_\_ Freq: \_\_\_\_\_

Race: \_\_\_\_\_ Asian \_\_\_\_\_ Black \_\_\_\_\_ Hispanic \_\_\_\_\_ White \_\_\_\_\_ Other \_\_\_\_\_  
Skin Complexion: \_\_\_\_\_ Facial Hair: \_\_\_\_\_ Beard \_\_\_\_\_ Mustache \_\_\_\_\_ Height: \_\_\_\_\_  
Weight: \_\_\_\_\_ Identifying Information: (i.e. scars/tattoos) \_\_\_\_\_  
Hair Color: \_\_\_\_\_ Glasses: \_\_\_\_\_

Reporting Agency: \_\_\_\_\_ Site #: \_\_\_\_\_ Date: \_\_\_\_\_  
Counselor: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Submit to: Kevin F. Green  
Program Administrator, Counseling & Testing  
500 S. Broad St. 3rd Floor  
Philadelphia, PA 19146

## Exhibit 4 (Cont.)

### COUNSELOR OBSERVATION

#### Pretest Counseling

1. How long did the observed pretest counseling session last? \_\_\_\_\_

2. Did the counselor (s) introduce her/himself and explain the purpose of the session? Yes\_\_\_\_ No\_\_\_\_

3. Did the counselor(s) use open-ended questions? (Give examples) \_\_\_\_\_

\_\_\_\_\_

4. Was a risk assessment conducted? Yes\_\_\_\_ No\_\_\_\_

If yes, \_\_\_\_\_ how was it conducted? (check appropriate box)

As an interactive process which provided the client(s) opportunities to ask questions and explored their ongoing behaviors and circumstances, (e.g., sexual history, STD history, drug use)?

\_\_\_\_ or as a data collection, form driven, appraisal of the client(s) behavior?

If no, please explain how this impacted the counseling session.

\_\_\_\_\_

5. Describe the HIV education and prevention information presented to the client (e.g., accurate, relevant, lecture format). \_\_\_\_\_

\_\_\_\_\_

### Pretest Counseling/Observation

#### Counselor Observation

6. Did the client have an opportunity to talk? If yes, how much? \_\_\_\_\_

7. Did the counselor(s) explore past attempts at prevention behaviors tried by the clients(s)?

Yes\_\_\_\_ No\_\_\_\_

If yes, describe how the counselor did this (e.g., reinforced successful strategies, discussed prevention failures or flawed strategies). \_\_\_\_\_

\_\_\_\_\_

8. Was a personalized incremental risk reduction plan(s) negotiated with the client(s), e.g., tailored to the behaviors, circumstances and special needs of the clients(s)?

Yes\_\_\_\_ No\_\_\_\_

If yes, was the plan documented in the record for review in post-test sessions or subsequent retesting sessions?

Yes\_\_\_\_ No\_\_\_\_

If no, what risk reduction messages were provided to the client? \_\_\_\_\_

\_\_\_\_\_

## Exhibit 4 (cont.)

### Pretest Counseling/Observation

#### Counselor Observation

9. \_\_\_\_\_ Were condoms discussed? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, did the counselor:

a. Demonstrate their proper use? Yes \_\_\_\_\_ No \_\_\_\_\_

b. Role play condom negotiating strategies? Yes \_\_\_\_\_ No \_\_\_\_\_

c. Provide condoms? Yes \_\_\_\_\_ No \_\_\_\_\_ How many? \_\_\_\_\_

10. Client was provided information on the following:

Counselor \_\_\_\_\_ Video/Pamphlet \_\_\_\_\_ Not Provided \_\_\_\_\_

a. Purpose of the test \_\_\_\_\_  
\_\_\_\_\_

b. Meaning of results \_\_\_\_\_  
\_\_\_\_\_

c. AIDS prognosis \_\_\_\_\_  
\_\_\_\_\_

d. Value of testing \_\_\_\_\_  
\_\_\_\_\_

e. Condom use \_\_\_\_\_  
\_\_\_\_\_

Please provide examples for questions #11-16.

### Pretest Counseling/Observation

#### Counselor Observation

11. How well did the counselor provide information at a level of comprehension which was consistent with the client's age and learning skills? Explain. \_\_\_\_\_  
\_\_\_\_\_

12. How well did the counselor provide/demonstrate culturally competent messages, (e.g., provided in a style and format respectful of cultural norms)? Explain. \_\_\_\_\_  
\_\_\_\_\_

13. How linguistically appropriate was the counselor with the client, (e.g., presented in a dialect and terminology consistent with the client's native language and style of communication)? Explain. \_\_\_\_\_  
\_\_\_\_\_

14. How do clients schedule appointments to return for results at the time of the pretest session? \_\_\_\_\_  
\_\_\_\_\_

15. How well did the counselor reinforce the importance of returning for test results/counseling? Explain. \_\_\_\_\_  
\_\_\_\_\_

16. What and when is related paperwork completed by the counselor? Explain. \_\_\_\_\_  
\_\_\_\_\_

## Exhibit 4 (Cont.)

### Pretest Counseling/Observation

Counselor Observation

#### OBSERVATIONAL COMMENTS

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#### COUNSELOR OBSERVATION

Post-Test Counseling

1. How long did the observed post-test counseling session last?

2. Did the counselor(s) introduce her/himself and explain the purpose of the session? Yes\_\_\_\_ No\_\_\_\_

3. Did the counselor(s) use open-ended questions? (Give examples) \_\_\_\_\_

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Yes\_\_\_\_ No\_\_\_\_

4. Did the counselor(s) ascertain if a personal risk reduction plan was established in the pretest session?

Yes\_\_\_\_ No\_\_\_\_

5. If yes to #4, did the counselor (check if "yes"):

- a. reinforce successful efforts?
- b. discuss failed efforts?
- c. provide additional coaching on risks remaining?

6. If no plan had previously been established, did the counselor (check if "Yes"):

- a. Negotiate a personalized, incremental risk reduction plan with the client(s), i.e. tailored to the behaviors, circumstances and special needs of the client(s) during the posttest session?
- b. Deliver global prevention messages independent of the clients personal risk behaviors and circumstances?
- c. Fail to discuss risk reduction in the post-test session?

If a risk reduction plan was discussed, was it revised or updated in the record or review in any subsequent retesting sessions? Yes\_\_\_\_ No\_\_\_\_

7. Did the counselor (s) (check if "yes")

Routinely recommend retesting at 3-6 months?

Recommend retesting if unsafe behaviors occurred within the last three months or should occur in the future?

Not discuss retesting?

### Posttest Counseling/Observation

Counselor Observation

#### OBSERVATIONAL COMMENTS (IF ANY):

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**Attachment E**

**City of Philadelphia  
Department of Public Health  
AIDS Activities Coordinating Office  
HIV Prevention Services Unit**

**PREVENTION COUNSELING PROGRAM  
PROGRESS REPORT AGENCY**

Program/Activity	Report Period
Contract Period	AACO Funding for this Program
Funding Source	Report Submitted by

**Section I – Goals**

- A. \_\_\_\_\_
  - 1. \_\_\_\_\_
  - 2. \_\_\_\_\_
  - 3. \_\_\_\_\_
  - 4. \_\_\_\_\_
  
- B. \_\_\_\_\_
  - 1. \_\_\_\_\_
  - 2. \_\_\_\_\_
  - 3. \_\_\_\_\_
  - 4. \_\_\_\_\_

**Section II – Progress in Meeting Goals**

A.  
Number \_\_\_\_\_  
Prevention Counseled \_\_\_\_\_

Number \_\_\_\_\_  
Counseled/ Not Tested \_\_\_\_\_

Number Tested \_\_\_\_\_  
Number of Result Sessions \_\_\_\_\_

Number of Counselor/s Hours Worked  
Site No. \_\_\_\_\_  
Site No. \_\_\_\_\_  
Site No. \_\_\_\_\_  
Site No. \_\_\_\_\_  
Site No. Totals \_\_\_\_\_

- B.
  - 1. \_\_\_\_\_
    - a. \_\_\_\_\_
    - b. \_\_\_\_\_
  
  - 2. \_\_\_\_\_
    - a. \_\_\_\_\_
    - b. \_\_\_\_\_
  
  - 3. \_\_\_\_\_
    - a. \_\_\_\_\_
    - b. \_\_\_\_\_

## **Exhibit 4 (Cont.)**

### **Section III Accomplishments**

- A. Programmatic
- B. Administrative
- C. Fiscal

### **Section IV – Challenges**

- A. Programmatic
- B. Administrative
- C. Fiscal

### **Section V – Plan of Action to Meet Challenges in Section IV**

- A. Programmatic
- B. Administrative
- C. Fiscal

### **Section VI – Collaboration**

Please footnote all changes that relate to the addition or deletion of agencies with which you hold Letters of Agreement.

- A. Names of agencies with Letters of Agreement on file and numbers of referrals:

Name	Number
------	--------

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

- B. Other (specify):

Name	Number
------	--------

- 1.
- 2.
- 3.
- 4.
- 5.

**Exhibit 4 (Cont.)**

**EQUIPMENT INVENTORY FORM  
HIV Prevention Services  
AIDS Activities Coordinating Office  
Revised 11/95**

Any equipment acquired with AACO funds, and a purchase price greater than \$500 should be entered below.  
This form should be submitted with the monthly invoice as the line item justification for that purchase.

Date Purchased	Equipment Description	Serial Number	Location
1.			
2.			
3.			
4.			
5.			

**Exhibit 5  
Attachment B**

**City of Philadelphia  
Department of Public Health  
AIDS Activities Coordinating Office  
HIV Prevention Services Unit**

**PROGRAM PROGRESS REPORT**

Program/Activity  
Contract Period  
Funding Source

Report Period  
AACO Funding for this Program  
Report Submitted by

**Section I – Goals**

- A.
  
- B.

  - 1.
  - 2.
  - 3.
  - 4.
  - 5.

**Section II – Progress in Meeting Goals**

- A.

## Exhibit 5 (Cont.)

### Attachment B (Cont.)

B. Enter goals stated in Section I-B of this report:

### Section III – Accomplishments

- A. Programmatic
- B. Administrative
- C. Fiscal

#### INSTRUCTIONAL TEMPLATE

City of Philadelphia  
Department of Public Health  
AIDS Activities Coordinating Office  
HIV Prevention Services Unit

Risk Reduction  
PROGRAM PROGRESS REPORT AGENCY  
(Enter agency name)

Program/Activity  
(Enter name of program or activity  
for this contract)

Report Period  
(Enter month being reported on)

Contract Period  
(Enter start and end dates)

AACO Funding for this Program  
(Enter dollar amount of contract/s)

Funding Source  
(Enter source, indicate City, State, or  
Federal completing)

Report Submitted by  
(Enter name of individual  
responsible for the report)

### Section I – Goals

- A. (Enter Section II part A of contract service provisions)
- B. (Enter goals that have been established with AACO Program Analyst)
  - 1.
  - 2.
  - 3.
  - 4.
  - 5.

## **Section II – Progress in Meeting Goals**

- A. (Enter statistics for the month using the table/s provided)

### **Program Progress Report**

- B. Enter the goals stated in Section I-B of this report:
  - 1. (Enter goal)
    - a. (Enter work statement/s)
    - b. (Enter progress and/or barriers to implementing work statement/s)
  - 2. (Enter goal)
    - a. (Enter work statement/s)
    - b. (Enter progress and/or barriers to implementing work statement/s)
  - 3. (Enter goal)
    - a. (Enter work statement/s)
    - b. (Enter progress and/or barriers to implementing work statement/s)
  - 4. (Enter goal)
    - a. (Enter work statement/s)
    - b. (Enter progress and/or barriers to implementing work statement/s)
  - 5. (Enter goal)
    - a. (Enter work statement/s)
    - b. (Enter progress and/or barriers to implementing work statement/s)

## **Section III – Accomplishments**

(Enter overall accomplishments, excluding statistics mentioned in Section II A and achievements mentioned in Section II B):

- A. Programmatic
- B. Administrative
- C. Fiscal

## **Section IV - Challenges**

(Enter overall challenges, excluding difficulties stated in Section II):

- A. Programmatic
- B. Administrative
- C. Fiscal

## **Section V – Plan of Action to Meet Challenges in Section IV (Enter plan)**

- A. Programmatic
- B. Administrative
- C. Fiscal

## Section VI – Collaboration

(Enter the number of referrals made to agencies of which you hold Letters of Agreement. Agencies with Letters of Agreement should become permanent entries.)

- Please footnote all changes that relate to the addition or deletion of agencies with which you hold Letters of Agreement.

A. Names of agencies with Letters of Agreement on file and numbers of referrals:

(Enter name of agency)

(Enter number of referrals)

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

B. Other (specify):

(Enter name of agency)

(Enter number of referrals)

- 1.
- 2.
- 3.
- 4.
- 5.

**Attachment C**  
**EQUIPMENT INVENTORY FORM**  
**HIV Prevention Services**  
**AIDS Activities Coordinating Office**  
**Revised 11/95**

Any equipment acquired with AACO funds, and a purchase price greater than \$500 should be entered below. This form should be submitted with the monthly invoice as the line item justification for that purchase.

	Date Purchased	Equipment Description	Serial Number	Location
1.				
2.				
3.				
4.				
5.				

**Exhibit 6**

**HOTLINE CALL RECORD - FY 97**

Data entry use only:

Prep By \_\_\_\_\_ Date \_\_\_\_\_ Time: Start \_\_\_\_\_ Finish \_\_\_\_\_

**CALL MADE BY GENDER**

- |                        |                  |
|------------------------|------------------|
| 1. Consumer            | 1. Female        |
| 2. Friend/partner/rel. | 2. Male          |
| 3. Hospital/clinic     | 3. Mixed group   |
| 4. Agency              | 4. Transgendered |
| 5. School              | 5. Unknown       |

**INSURANCE**

- |                     |
|---------------------|
| 1. MA/SSI           |
| 2. Military/VA      |
| 3. Employer/Private |
| 4. None             |
| 5. Unknown          |

**RACE/ETHNICITY**

- |   |
|---|
| 1. African-American                                   |
| 2. Caucasian  |
| 3. Hispanic/Latino                                    |
| 4. Asian-American/<br>Pacific Islander                |
| 5. Native American/Aleutian/<br>Native Alaskan/Eskimo |
| 6. Other  |
| 7. Unknown  |
| 8. N/A  |
| 9. Refused  |

**AGE \_\_\_\_\_**

- |                |
|----------------|
| 1. Mixed Group |
| 2. Unknown     |
| 3. Refused     |

6. CHOICE Counselor

7. Other

- |            |
|------------|
| 6. N/A     |
| 7. Refused |

- |                           |
|---------------------------|
| 1. Advocacy               |
| 2. Call in Spanish        |
| 3. Call in other language |
| 4. TTY                    |

PA COUNTY  
CODE \_\_\_\_\_

ZIP CODE \_\_\_\_\_

- |                                 |
|---------------------------------|
| 1. Outside of Phila. Metro area |
| 2. Unknown                      |
-

## SUBJECT

- |                             |                |                                       |                                 |
|-----------------------------|----------------|---------------------------------------|---------------------------------|
| 1. Abortion                 | M              | Teen Access                           | 8. Financial assistance/MA      |
| 2. Abuse                    | A. Rape        | D. Parental consent                   | 9. Food/shelter                 |
| 3. Adoption                 | B. Incest      | E. Out-of-state                       | 10. General health              |
| 4. Birth control            | C. Life-threat | F. Court-bypass                       | 11. Gyn                         |
| A. Cervical cap             |                | G. Undecided                          | 12. Infertility                 |
| B. Depo Provera             |                |                                       | 13. Healthy Start               |
| C. Diaphragm                |                |                                       | 14. HIV/AIDS *                  |
| D. Female condom            |                | Abortion/Prenatal Care/<br>Pregnancy: | 15. Legal/legislative           |
| E. Foam                     |                | H. First trimester                    | 16. Menstruation cycle          |
| F. IUD                      |                | I. Second trimester                   | 17. Pregnancy/childbirth        |
| G. Male condom              |                | J. Third trimester                    | 18. Pregnancy options           |
| H. Norplant                 |                | K. Unknown                            | 19. Pregnancy support/parenting |
| I. Pills                    |                | L. N/A                                | 20. Pregnancy test/symptoms     |
| J. Post-Coital pill         |                |                                       | 21. Prenatal care               |
| K. Sponge                   |                |                                       | 22. Sexuality                   |
| L. Natural FP/CMBBT         |                |                                       | 23. STD/infection               |
| 5. Counseling/mental health |                |                                       | 24. Sterilization               |
| 6. Drug abuse               |                |                                       | 25. Other                       |
| 7. Education/job training   |                |                                       |                                 |

## HIV/AIDS

Type of Call	Consumer's Status		Consumer's Concerns			
1. Case management	6. Symptoms	A. HIV	1. Blood transfusion/products	6. Pediatric		
2. General Info	7. Testing	B. HIV+asymptomatic	2. Caregiver/partner	7. Sexual	A. F/M	
3. Housing	8. Transmission	C. HIV+ symptomatic	3. Casual contact	8. Work related	B. M/M	
4. Medical care	9. Treatment	D. AIDS	4. Health care related	9. Other	C. F/F	
5. Support/counseling	10. Other	E. Unknown	5. IDU	10. Unknown	D. Unknown	
	F. N/A	11. N/A	E. N/A			

## HOW HEARD OF HOTLINE

1. Called before	7. Other outreach/materials	13. SEPTA car card	19. Campaign E
2. Friend/relative/partner	8. Newspaper ad/coverage	14. Healthy Start Campaign	20. Unknown
3. Agency	9. Radio ad/coverage	15. Campaign A	21. Other
4. Hospital/clinic	10. TV ad/coverage	16. Campaign B	22. N/A
5. Private Practitioner	11. Phone book/information	17. Campaign C	
6. CHOICE outreach/ materials	12. School	18. Campaign D	

## NUMBER CALLED

- |                   |                   |        |
|-------------------|-------------------|--------|
| 1. 985-3300       | 5. 1-800-84-TEENS | 1. FPC |
| 2. 985-AIDS       | 6. Other          | 2. MCH |
| 3. 1-800-985-AIDS | 7. Transfer from  |        |
| 4. 1-800-876-MOMS | 8. 1-800-662-6080 |        |

## FUNDING SOURCE

- |                      |                     |
|----------------------|---------------------|
| 4. AACO              | 6. Other Non-Funded |
| 5. Ryan White        |                     |
| 3. Abortion/adoption |                     |
| 7. AIDS Fact Line    |                     |

## REFERRAL SUMMARY

**Exhibit 7**

**ATTACHMENT A**

AGENCY: \_\_\_\_\_

PROGRAM: \_\_\_\_\_

FUNDING SOURCE: FORMULA ( ) SUPPLEMENTAL ( )

CONTRACT PERIOD: \_\_\_\_\_

PROGRAM ANALYST: \_\_\_\_\_

AACO MONTHLY DATA FORM FOR THE MONTH OF \_\_\_\_\_  
(one month only)

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR EACH TYPE OF UNIT OF SERVICE YOU PROVIDE. PLEASE USE ONE SHEET FOR EACH SERVICE UNIT IDENTIFIED IN YOUR SERVICE DESCRIPTION PAGE. **PLEASE DO NOT REVISE THIS FORM.**

SERVICE UNIT TYPE: \_\_\_\_\_

1. Number of units of service provided this month (current contract period): \_\_\_\_\_

2. Number of new unduplicated clients provided this service this month: \_\_\_\_\_

(a. clients not previously reported. A new client is an individual who received services from a particular provider for the first time ever. A person can be new to a provider only once. Clients who receive no services for a time, or clients who are considered deactivated by the provider, should not be reported as new every time they return or are reactivated. A provider should determine whether clients are old or new with readily available information. It is not expected to retrieve archived records or take other unreasonable measures.)

3. Total number of unduplicated clients provided this service this month: \_\_\_\_\_

4. Number of unduplicated clients provided this service from the start of the contract period through the month being reported: \_\_\_\_\_

**Exhibit 7 (Cont.)**

**ATTACHMENT B**

**RYAN WHITE TITLE I QUARTERLY NARRATIVE REPORT**

Providers who receive Title I Formula and Supplemental funding as well as City funding for AIDS treatment services (home health, case management, transportation, etc.) through the AIDS Activities Coordinating Office, must complete this narrative report on a quarterly basis. The reporting quarters run on a calendar year schedule, i.e. January through March, April through June, July through September and October through December. **PLEASE COMPLETE A SEPARATE FORM IN CONNECTION WITH EACH TITLE I FORMULA, SUPPLEMENTAL AND CITY FUNDED AIDS TREATMENT SERVICE CONTRACT THAT YOU RECEIVE THROUGH AACO.** Do not complete this form in connection with CDC funded Prevention/Education contracts your agency may receive through AACO.

AGENCY NAME:

PROGRAM:

Year 07 Amount: \_\_\_\_\_ Funding Source: \_\_\_\_\_ Formula \_\_\_\_\_  
Supplemental \_\_\_\_\_  
City General \_\_\_\_\_

1. Briefly describe the services offered by this program during the past quarter. Describe the target population(s) served by this contract and how this program has met the needs of this population. For the first report of this contracts fiscal year (i.e. for Supplemental - April through June and Formula - January through March), indicate the program's annual goals. Subsequent quarterly reports should indicate any AACO pre-approved changes made to this program's annual goals and the reason(s) for same.

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2. Describe the progress made by this program in meeting its annual goals during the past quarter. Please include the number of unduplicated clients served and the number of service units (case management encounters, visits, trips, etc.) provided to those clients. In some cases your program may have multiple service units. You should refer to your AACO service provisions as well as the AACO Monthly Data Forms in connection with this program in completing this section. If this program did not meet its service goals during the past quarter, please indicate the reason(s) and describe corrective steps either planned or being implemented.

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3. If the services offered by this program are Medicaid eligible (i.e. case management, primary medical care, home health, dental and nutritional counseling) indicate a) how many of the reported unduplicated clients who received services during the quarter (indicated in question #2 above) were Medicaid eligible and b) how many of these Medicaid eligible clients reported in #3a received this service funded by Medicaid or Health Choices?

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**Exhibit 7 (Cont.)**

- 4. a) Briefly discuss any significant barriers that your program has experienced in the provision of this service to your clients, problems encountered in delivering services and unmet needs.

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- b) Describe how this program has worked to overcome the barriers indicated above. Also, indicate any actions that were taken or plans formulated to respond to these areas of concern.

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- 5. Describe technical assistance needs this program has identified.

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- 6. Describe any changes in staff funded by this contract during the past quarter (i.e. has anyone been hired, fired, promoted). Indicate if new job titles were created. Provide job descriptions as appropriate.

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- 7. Describe any organizational budget changes in the last quarter that affect the delivery of services in this contract.

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- 8. Discuss trends and share insight regarding demand/needs that affect or may affect the provision of this program's services from your organization's point of view. Provide documentation as appropriate.

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- 9. Indicate any significant programmatic accomplishments/highlights relevant to the quarter.

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10. Indicate the level of involvement and participation of Persons With HIV/AIDS in the design and delivery of Title I funded services both at your agency and with regard to this particular program. Please be as specific as possible (i.e. indicate the number of consumers who are involved in the delivery of Title I services, the number of paid versus volunteer HIV consumer staff, support groups conducted by and for Persons With HIV/AIDS, HIV consumer needs assessments conducted by your agency, etc.). Please indicate how your agency and/or this program documents HIV consumer involvement.

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11. Indicate any mechanisms/ processes in place at your agency which allows for the assessment of Title I funded services by Persons With HIV/AIDS.

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**Exhibit 7 (Cont.)**

**STANDARD  
ANNUAL ADMINISTRATION REPORT**

**CONTACT INFORMATION**

Provider Name (line 1 of 2):

Provider Name (line 2 of 2):

Address (line 1 of 2):

Address (line 2 of 2):

City:

State:

Zip Code:

Contact Name:

Title:

Phone:

Fax:

2. Provider Number:

3. Reporting Period (Month/Day/Year):

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ through \_\_\_\_ / \_\_\_\_ / \_\_\_\_

4. Zip Code of Principal Site:

5. Total Number of Provider Sites:

6. Provider Type (circle one):

- (01) Hospital or hospital-based clinic
- (02) Public-funded community health center
- (03) Public-funded community mental center
- (04) Other community-based service organization
- (05) PWA coalition
- (06) Health department
- (07) Other public agency
- (08) Solo/group private health practice
- (09) Other
- (99) Unknown

7. Ownership Status (circle one):

- (01) Public/local
- (02) Public/state
- (03) Public/federal
- (04) Private/nonprofit
- (05) Private/for profit
- (06) Unincorporated
- (99) Unknown

8. Do members of minority racial/ethnic groups constitute a majority of Board members and/or a majority of staff (volunteer or paid) providing care? (circle one)

- (1) Yes      (2) No      (9) Unknown

**Exhibit 7 (Cont.)**

**STANDARD  
ANNUAL ADMINISTRATIVE REPORT (Cont.)**

**Total Number of Clients (nnn,nnn = number, 999,999 = unknown)**

9. Total Unduplicated Number of Clients Served During Reporting Period	
10. Number of New Clients	
11. Number of Clients Without Client-Level Information (anonymous, drop-in)	
12. Number of clients who are:	Male
	Female
13. Number of Clients who are:	White (Non-Hispanic)
	Black (Non-Hispanic)
	Hispanic
	Asian/Pacific Islander
	American Indian/Aleutian/Native Alaskan/Eskimo
14. Number of clients who are:	Under 13 Years of Age
	13-19 Years of Age
	Age 20 and Over
15. (Medical Providers only)	Men who have sex with men
Estimated % of Adult/Adolescent	Injection Drug Use (IDU)
Clients by exposure category:	Men who have sex with men
AND IDU 999.9 = Unknown	Heterosexual contact
	Other/Undetermined
16. HIV/AIDS Status:	Estimated % of clients who have HIV (non-AIDS)
999.9 = Unknown	Estimated % of clients with an AIDS diagnosis

**Exhibit 7 (Cont.)**

**STANDARD  
ANNUAL ADMINISTRATIVE REPORT (CONT.)**

17. Total Office-Based Health Service Contacts this Reporting Period  
(0= no contacts but deliver service; nn,nnn,nnn = number contacts;  
99,999,998 = not applicable, does not deliver service; 99,999,999 = unknown)

_____	Medical care visits
_____	Dental care visits
_____	Mental health treatment/therapy/counseling visit
_____	Substance abuse treatment/counseling visits
_____	Rehabilitation services

18. Case Management Encounters  
(0= no contacts but deliver service; nn,nnn,nnn = number contact;  
99,999,998 = not applicable, does not deliver service, 99,999,999 = unknown)

_____	Face to face encounters
_____	Other encounters

19. Home Health Care Visits  
(0 = no visits but deliver service; nn,nnn,nnn = number visits;  
99,999,998 = not applicable, does not deliver service; 9,999,999 = unknown)

_____	Paraprofessional	(4 hours = 1 visit)
_____	Professional	(2 hours = 1 visit)
_____	Specialized	(2 hours = 1 visit)

**Exhibit 7 (Cont.)**

**STANDARD  
ANNUAL ADMINISTRATIVE REPORT (CONT.)**

20. Number of HIV/AIDS Clients who Received these Services:  
(0 = no contacts but deliver service; n,nnn,nnn = number contacts;  
9,999,998 = not applicable, does not deliver service; 9,999,999 = unknown)

_____	Residential hospice	_____	Housing assistance
_____	In-home hospice	_____	Food bank/home
_____	Buddy/companion	_____	Delivered meals
_____	Client advocacy	_____	Transportation
_____	Other counseling	_____	Education/risk reduction
_____	Day or respite care	_____	Foster care/adoption
_____	Emergency financial assistance	_____	Other services

21. HIV/AIDS Funding (for HIV/AIDS clients):  
(nnn,nnn,nnn = actual dollar amount; 999,999,998 = not applicable; 999,999,999 = unknown)

_____	Title I CARE	_____	State/local public sources (other than
_____	Title II CARE		
_____	Title III CARE	_____	Other sources (fund-raising, contributions,etc.)
_____	Section 329, 330, 340	_____	Other Federal
_____	HIV Pediatrics Demonstration	_____	Funding
_____	Projects, other Federal Pilots		

22. Expenditures for HIV/AIDS Related Services  
(nnn,nnn,nnn = amount spent; 999,999,998 = not applicable; 999,999,999 = unknown)

_____	Direct service staff	_____	Other direct
_____	Medications	_____	Total Expenditures
_____	Contracted services		

23. Staffing  
(000.0= applicable but no FTEs; nnn.n = number FTEs; 999.9 = not applicable)

Total paid staff in full-time equivalent	_____	Total volunteer staff in full-time equivalents	_____
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24. Staff Added  
Were Title I and/or Title II CARE funds used to add any paid staff?  
(circle one for each category)

Physicians (1) Yes (2) No (9) Unknown	Licensed mental health staff (1) Yes (2) No (9) Unknown
Nurses, physician assistants, nurse practitioners (1) Yes (2) No (9) Unknown	Case Managers (1) Yes (2) No (9) Unknown
Dentists (1) Yes (2) No (9) Unknown	Clerical/support staff (1) Yes (2) No (9) Unknown

## Exhibit 7 (Cont.)

Attachment D

## CITY OF PHILADELPHIA

DEPARTMENT OF PUBLIC HEALTH  
500 S. Broad Street – 2nd Floor  
Philadelphia, PA 19146  
ESTELLE B. RICHMAN  
Health Commissioner  
JESSE MILAN, JR., ESQ.  
Director  
AIDS Activities Coordinating Office

March 13, 1997

Dear Title I Provider:

I am writing to inform you that federal Health Resources and Services Administration (HRSA) guidelines require your agency to have procedures and internal controls in place to document and ensure that all clients receiving Title I funded services are "eligible beneficiaries." Eligible beneficiaries are Persons with HIV/AIDS and their families.

This mandatory documentation applies to all Ryan White funded services with only limited exceptions (for example, services to non-HIV infected family members or anonymous services).

Consistent with HRSA mandates, AACO requires the following of all service providers who receive Ryan White Title I funds in the nine county Philadelphia planning region:

- 1 The Ryan White provider should ensure that confidential primary documentation of a client's positive HIV serostatus is included in the client's file. This documentation must be in the form of either a lab test result issued by the testing laboratory or a physician's certification.
- 2) In cases where referrals are made for Ryan White funded services, other than case management or primary care, from another Ryan White funded provider, it is not necessary for the agency providing the new service to maintain HIV status documentation in the client's file. Rather, the referring Ryan White agency will maintain this information. The client file located at the site providing the service must contain a reference to this HIV documentation at the referring site. This will be either in the form of a certified referral form (signed and on agency letterhead) or a notation that such eligibility has been confirmed, including the name of the person and organization verifying eligibility, date, nature and location of primary documentation.
- 3) As stated above, where it is appropriate for a Ryan White agency to provide services to HIV-affected clients, it is the responsibility of the provider to maintain documentation in each client's chart as to the client's relationship to a Person With HIV/AIDS.

Your assigned AACO Program Analyst, during an upcoming site visit, will check client files to verify that the above referenced documentation is maintained by your agency.

If you have any further questions concerning this matter, please contact John Cella, Administrator for Ryan White Title I programs, or your assigned AACO Program Analyst.

Once again, thank you for your interest in this most important matter.

Sincerely,

Estelle B. Richman  
Health Commissioner  
EBR/d

cc: John Cella

ation programs, assures the well-being of all residents through its environmental protection programs and offers essential treatment to residents with specialized health needs. The Department's programs are used by Philadelphians of all ages and races and by residents throughout the city.

.03 Information and auditing and reporting requirements for the following Department of Public Health program services are provided in the referenced Sections of the Audit Guide.

- AIDS Activities Coordinating Office (Section 6100)
- Coordinating Office for Drug and Alcohol Abuse Programs (Section 6200)
- Office of Mental Health and Mental Retardation (Section 6300)
- Office of Maternal and Child Health (Section 6400)
- Division of Disease Control (Section 6500)

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## SECTION 6100

### AIDS ACTIVITIES COORDINATING OFFICE

#### Section 6101 - General Information

- .01 The mission of the AIDS Activities Coordinating Office (AACO) is to stop the transmission of the Human Immunodeficiency Virus (HIV) in Philadelphia through education and prevention activities and to provide services to people with AIDS and to individuals with HIV infection related conditions. The Office is charged with coordination of all City of Philadelphia activities related to AIDS.
- .02 The AIDS Activities Coordinating Office includes four major divisions. These are: Medical Affairs, Policy and Planning; AIDS Prevention and Education Services; AIDS Agency Services; and AIDS Program Administration. Of these four divisions, the two with responsibility for the development and monitoring of contract service activities are AIDS Agency Services and AIDS Program Administration. Program development and monitoring are the responsibility of the former while contract and fiscal management rests with the latter.

#### Section 6110 - Program Descriptions and Operations

- .01 Some of the services provided by AACO include the following:
  - a. AIDS Care Services:

Support services consist of those services that are provided directly to those individuals who are HIV positive and/or have been diagnosed as having Acquired Immunodeficiency Syndrome (AIDS). In addition, care services are intended to provide support for family members and the loved ones of those who are infected with the Human Immunodeficiency Virus (HIV). Services usually consist of helping the individual in maintaining their self worth, independence, and human dignity while living with AIDS.

AIDS case management services consists of performing a needs assessment and developing, implementing, and monitoring a service/care plan as well as arranging for or referring a client to needed services. Such services, to which clients may be referred or which are arranged for clients, can be any services needed for activities of daily living, caring for HIV/AIDS infected individuals, and alleviation of psychological and social consequences of infection. Case management services require a thorough needs assessment and the development and monitoring of a formal services plan for the client.
  - b. Education:

Education consists of activities aimed at changing knowledge, attitudes, and behaviors of individuals or groups for the purpose of motivating them to avoid contracting or transmitting HIV or alleviating anxiety about transmission and effects of the virus. Education is further defined as activities geared to increasing knowledge and skills of those who perform services for the HIV infected or their friends, families or significant others. Education activities normally consist of presentations, consultations, training, instruction, outreach, hotline operations, and media efforts.
- .02 All agencies under contract with the City of Philadelphia through AACO must submit monthly financial status reports. The purpose of the procedures package is to effectively and efficiently process requests for payment from each contract agency. The package indicated what types of reports were required, information to be included in each report and examples of how each report should look.
- .03 In order for an agency to invoice AACO (City of Philadelphia) for the expenditure of funds allocated through a contract, the submission of a cover letter, an invoice, a monthly budget performance report, and a personnel roster is required. Authorized advance payments must be requested in a letter. Additional information may also be required. Actual requirements for the preceding documents are detailed as follows:

## SECTION 6100 (cont.)

Invoices may differ in format but must include all of the following:

- a) date submitted;
- b) period of service for which invoice is being submitted for;
- c) contract number;
- d) contract name;
- e) current period's expenses (as categorized in the contract budget.)

(Exhibit 1) Monthly Budget Performance Reports must accompany each invoice. This report identifies expenditures in the categories listed on the AACO approved line item budget form and must show current month and year-to-date expenses as well as total budget and the total amount remaining for each line item of the budget. Each column (current month, year-to-date, annual budget, budget amount remaining) must be totaled. Revenue offsetting program/contract costs must be indicated and subtracted from total expenses in all columns.

(Exhibit 2) Personnel Rosters must also accompany each invoice. Each roster must identify names of personnel being charged to a specific program/contract as well as expenditures for each position title. Columns showing current month and year-to-date expenses as well as total budget and total amount remaining for each position must be included and each column must be totaled.

Advance Payments allow for a percentage of the total contract to be paid upon conformation of the contract and must be requested in the form of a letter on Agency/Corporate letterhead. All of the following must be included in each letter:

- a) contract name;
- b) contract number;
- c) signature of authorized corporate official;
- d) percentage of the contract total requested and the amount.

## Section 6120 - Federal CFDA Numbers/Other Regulations

.01 The following Federal CFDA numbers are applicable to AACO Programs:

Program	CFDA No.
AIDS Surveillance and Seroprevalence Grant	93.118, 93.944
AIDS Prevention Project	93.940
HIV Emergency Relief Grant (Formula) (Ryan White)	93.915
HIV Emergency Relief Grant (Supplemental) (Ryan White)	93.914
HIV Early Intervention Project	93.918
HIV Early Intervention Services Network Demonstration Project	93.118

## **Section 6130 - Program Compliance Procedures**

- .01 As discussed in Sections 300 and 500 of this Audit Guide, each City of Philadelphia Department program has specific auditing requirements. These requirements are in addition to those areas of audit specified in Sections 300 and 500 of this Guide. The audit requirements listed on the following pages are not all inclusive and do not represent an audit program for conducting a financial and compliance audit of the program(s). The audit requirements listed are presented as highlights of areas of special interest to the Department. Any deficiencies noted as a result of the procedures are to be disclosed in the Schedule of Findings and Questioned Costs.

### **Program Description and Personal Data Questionnaire**

- .02 The AIDS Agency Services Unit monitors and evaluates programs and direct services for persons with HIV infection. These services include, but are not limited to, AIDS education, support, case management, housing, and HIV counseling and testing. Epidemiology and miscellaneous service contracts are also the responsibility of this unit. All agencies are required to report to their respective AACO program analyst on the progress of the services being rendered.
- .03 Each service is different in nature and requires specific reporting procedures to be followed; however, there are a few reports which AACO requires all contract agencies to submit. These reports include a Position Description and Personal Data Questionnaire (PDPDQ) (Exhibit 3) and monthly statistical and narrative reports. At this time, the PDPDQ is the only standardized form relevant to all AACO contract agencies. Each Agency is required to submit this form to AACO within six months of the contract effective date for all personnel funded by the contract. New staff are required to fill the questionnaires out at the time of their hiring and the agency must submit the forms within thirty (30) days of the hiring date.
- .04 Audit procedures are to include a determination that the PDPDQ is on file at the Organization and that the reporting and filing requirements described above have been met

### **Aids Care Services**

- .05 AACO has many contracts with agencies whose services are provided directly to those individuals who are HIV positive and/or have been diagnosed as having AIDS. Care services help individuals maintain their self worth, independence and dignity while living with AIDS. Such services include, but are not limited to primary care, dental, skilled nursing, transportation, homemaker services, respite care, case management and other required services. Quarterly narrative reports (see Exhibit 7) must contain specific information. In addition to the reporting requirements, the resultant auditing procedure is also stipulated.
- Skilled nursing agencies are required to submit in their monthly reports statistics reflecting the number of Medicaid waivers completed per month. The auditor should determine, on a test basis, that reports include this information and are in compliance with the contract service provisions.
  - Agencies providing homemaker services must include in their monthly reports statistics reflecting the number of clients served each month and the number of hours provided per client per month. Minimum and maximum numbers of clients and hours are provided in the contract service provisions. The auditor should determine, on a test basis, that reports include this information and are in compliance with the provisions.
  - Agencies providing transportation services must include statistics reflecting the number of trips taken per month and the number of clients transported per month in each monthly report. As with homemaker services, minimum and maximum numbers of trips to be taken and clients to be transported are provided in the contract service provisions. The auditor should determine, on a test basis, that reports include this information and are in compliance with the provisions.
- .06 AIDS Case Management services consist of thorough assessments of clients' needs and the development and monitoring of a formal services plan for each client. Agencies providing this type of service assign case managers who aid clients with their daily living needs. These needs vary with each client; therefore, documentation of services provided is extremely important.

- .07 AACO's analytical staff must be able to make their programmatic decisions based on monthly reports from provider agencies. These reports are similar in format to other services' monthly reports; however, more specific information is required. Although no standardized forms are available to agencies at the present time, AACO program staff are in the process of developing a standardized statistical form to be included in future contracts. Nonetheless, statistical information regarding number of clients seen per month, per case manager, is important to AACO.
- .08 Currently, all case management service providers are required to keep a file on each client served. Each client case record file should contain the following list of documents:

### **Assessment Form**

- Data Entry Form
  - Case Management - Client Agreement Form
  - Authorization to obtain release of information.
  - Surveillance letters:
    - (a) To physician
    - (b) To AACO Surveillance Unit.
  - Agency Consent Form
  - Buddy Agreement Form
  - Buddy Program Work Sheet
  - Treatment Care Plan
  - Physician Release Form
  - Case Management Activities Log
  - Progress Notes Form
- .09 The auditor should determine on a test basis that:
- The statistical information reported by the organization to AACO on the monthly statistical reports are traceable to, and in agreement with, supporting records.
  - Client files contain the information required under Section 6130.21.

### **Counseling and Testing Services**

- .10 The counseling and testing programs are required to provide AACO with a monthly report (Exhibit 4) which includes various statistical, programmatic, and staffing information.
- .11 The auditor should determine, on a test basis, that the:
- Statistical information included on the report is traceable to records maintained by the Organization to support the report submitted to AACO. The statistical information needed to be verified by the auditor includes number of individuals pre-tested, number of individuals counseled and not tested, number of individuals tested, and number of individuals post-tested. The source document to be used in verifying the above information is included in Exhibit 4.

### **HIV Prevention: Education and Risk Reduction**

- .12 The education and risk reduction programs are required to provide AACO with a monthly report (Exhibit 5) which includes various statistical, programmatic, and staffing information.
- .13 The auditor should determine, on a test basis that the statistical information included on the report is traceable to records maintained by the organization to support the report(s) submitted to AACO.
- .14 For hotline services, all calls received must be documented on a hotline call record form (Exhibit 6). This is a standardized form which must be completed by a counselor during each telephone conversation.
- .15 The auditor should determine, on a test basis, that the hotline call record forms are utilized and maintained on file at the organization.

## **AIDS Education**

- .16 Other than the Position Description and Personal Data Questionnaire (PDPDQ) which all providers must submit to AACO, AIDS Education Programs must submit a monthly statistical report with narratives within ten working days after the end of each month. These reports document the various education activities performed by each agency. There are no format requirements; however, each report should include the same information regarding the activities conducted during the report period, projected activities for subsequent periods, problems encountered and how they were solved, and supporting statistical data for quantifiable information.
- .17 Each agency is required to track participant attendance for all presentations, workshops, consultations, trainings, and instructions. Attendance sheets are the responsibility of the agency and may be in whatever format they choose to follow; however, participants' names, instructors'/educators' names, and the date of the activity must be included on the form.
- .18 Before and after each educational activity, the instructor/educator must test the knowledge of each participant. This is done through a standardized test which the agency or AACO has developed. Each test, although very often the same, must be presented as two separate distinguishable tests. The first test should be labeled "Pre-test" and the second test should be labeled "Post-test."
- .19 The monthly statistical/narrative report should include a summary of the above information.
- .20 The auditor should determine, on a test basis, the counseling and testing services, that:
  - Statistical information reported corresponds with supporting documents/records maintained at the Organization.
  - Attendance records are utilized and kept on file for participants attending presentations, workshops, consultations, training and instruction.

## **Section 6140 - Financial Compliance Procedures**

### **Revenues:**

- .01 Program-funding is the most common method employed by AACO to fund its provider agencies. This method allows AACO to fund a provider agency's actual eligible expenditures for a provider agency's service(s), offsetting these expenses by anticipated revenues to be received directly by the provider, and establishing the remaining deficit as its authorized level of funding (allocation). Reimbursement is affected on a "last-dollar-in" basis and is based upon actual eligible expenses incurred less actual revenue generated, up to the maximum contract funding.
- .02 Audit procedures should include the following:
  - Does the Agency have a system in place to adequately account for all applicable income received or earned by the agency and that such income was properly reported to AACO.
  - Determine that billings to AACO and reimbursement from AACO are net of other non-AACO revenue.

## **Section 6150 - Supplemental Financial Schedules and Reports**

- .01 The organization's audit report must include the following supplemental financial schedule for each City of Philadelphia contract with \$300,000 or more of expenditures in addition to the financial statements as specified in Sections 400 and 500 of this Audit Guide. A designation has been made for the supplemental schedule required for a "single audit" report (Section 400) on a "program audit" report (Section 500). The auditor will be required to issue an opinion on the Supplemental Schedules listed below as specified in Section 400 of this Audit Guide.

Supplemental Financial Schedule	Section Ref. to Sample Format	Single Audit Report	Program Audit Report
- Schedule of Program Expenditures and Program Revenue (1)	6150.02	Yes	No (2)

**Explanatory Notes:**

(1) The schedule must reflect the categorization of expenditures by the AACO budget with the organization.

(2) The categories of expenditures provided on the program audit financial statement should coincide with the categories of expenditures on the AACO budget.

**Section 6150.02**

**ABC NOT-FOR-PROFIT CORPORATION  
AACO CONTRACT NUMBER XX-XXXX  
STATEMENT OF PROGRAM EXPENDITURES AND PROGRAM REVENUE  
FOR THE YEAR ENDED JUNE 30, 19XX**

**Expenditures**

Personnel:	
Salaries	\$ XXX,XXX
Fringe benefits	XX,XXX
Total personnel expenditures	\$ XXX,XXX

**Operating**

Occupancy	XX,XXX
Renovation	X,XXX
Communications	XXX
Office Supplies	XXX
Education/Program supplies	X,XXX
Travel	X,XXX
Contract Services	X,XXX
Insurance	X,XXX
Condoms	X,XXX
Total operating expenditures	XX,XXX

**Equipment:**

Purchase	XX,XXX
Lease/rental	X,XXX
Repairs	X,XXX
Total equipment expenditures	XX,XXX
Total direct expenditures	XXX,XXX
Administration	XX,XXX
Total expenditures	XXX,XXX
Program Revenue	(X,XXX)
Net AACO funded expenditures	\$ XXX,XXX

**AACO - EXHIBITS  
TABLE OF CONTENTS**

EXHIBIT	DESCRIPTION
1	Monthly Budget Performance Report
2	Personnel Roster
3	Position Description and Personal Data Questionnaire
4	Counseling and Testing Package
5	Education and Risk Reduction Package
6	Hotline Call Record Form
7	Aids Care Services/Ryan White Package

Exhibit 2

AIDS AGENCY XYZ  
CONTRACT XX-XXXX

	Budget		Per Contract	Budget	Remaining
	August Billings	Cumulative Billings			
Personnel Service (by position):					
Prog. Coord.					
B. Smith	\$ 3,333		\$ 6,666	\$ 40,000	\$ 33,334
Counselor					
J. Jones	2,500	5,000	30,000	25,000	
Educator					
A. Carter	2,667	5,334	32,000	26,666	
Secretary					
M. Cuyler (hired 7/15/XX)			1,625	2,437	19,500 17,063
Educator					
C. Jackson (term. 7/31/XX)			-0-	2,667	32,000 29,333
D. Kelly (hired 8/1/XX)	2,667		2,667	-0-	(2,667)
Counselor					
G. Martin	2,500	5,000	30,000	25,000	
Counselor					
F. Berk	2,500	5,000	30,000	25,000	
Education					
Vacant	-0-	-0-	32,000	32,000	
Phlebotomist					
N. Mill (hired 8/10/XX)			718	718	21,500 20,782
Total	\$ 18,510	\$ 35,489	\$ 267,000	\$ 231,511	

ATTACHMENT C  
Exhibit 3

Position Description and Personal Data Questionnaire City of Philadelphia Aids Activities Coordinating Office  
Personnel Action Plan

1. Position Number
2. Request for personnel action on Existing position New Incumbent New Position (Explain) Position (Explain) Conversion
3. Last Name First Mi
4. Agency
5. Service, division, unit 6. Total working hrs per week in agcy. 7. No. working hrs. chgd to county prog.
8. Requested "Pap" title 9. Usual working title 10. Annual salary (for total hrs. worked, #6)
11. Describe types of work you do during working hours on County Program. Use separate paragraph for each kind of work and explain in detail. List your duties in order of importance, showing estimate of time spent on each duty by percentage, fractions, days or hours in "Time" column. Special or occasional duties should be last.

Time Work Performed

(Continue on additional sheets)

**Exhibit 1****BUDGET STATEMENT  
AIDS AGENCY XYZ  
COUNSELING SERVICES  
(CONTRACT XX-XXXX)  
AUGUST, 19XX**

	August	Year To-Date	Total Budget	Budget Remaining
<b>Expenses</b>				
Personnel:				
Salaries	\$ 18,510	\$ 35,489	\$ 267,000	\$ 231,511
Benefits	2,124	4,072	30,638	26,566
Other	-0-	-0-	300	300
Sub-total personnel	20,634	39,561	297,938	258,377
<b>Operating:</b>				
Occupancy	3,045	6,090	36,540	30,450
Renovation	-0-	-0-	-0-	-0-
Communications	1,245	1,900	8,700	6,800
Office Supplies	603	603	2,500	1,897
Education/ Program supplies	262	524	1,750	1,226
Travel	174	348	2,784	2,436
Contract Services	-0-	-0-	-0-	-0-
Insurance	85	170	1,025	855
Condoms	150	250	1,500	1,250
Sub-total operating	5,564	9,885	54,799	44,914
<b>Equipment:</b>				
Purchase	-0-	-0-	3,000	3,000
Lease/rental	39	78	468	390
Repairs	-0-	-0-	500	500
Sub-total equipment	39	78	3,968	3,890
Subtotal direct	26,237	49,524	356,705	307,181
Administration	933	1,874	13,500	11,626
Sub-total	27,170	51,398	370,205	318,807
Revenue	(500)	(1,000)	(7,121)	(6,121)
Grand total	\$ 26,670	\$ 50,398	\$ 363,084	\$ 312,686

**Exhibit 4**

**Attachment B  
PATIENT FOLLOW-UP/PARTNER NOTIFICATION FORM**

Check One:

Patient Follow-Up  
Date Tested

Partner Notification  
Date Interviewed

Name: _____		Alias/Nickname: _____	
Address: _____ _____		DOB: _____	
		Age: _____	
		Sex: _____	
Work Address/Hangouts: _____ _____		Marital Status: _____	
		Work Hours: _____	
Home Phone #: _____		Work Phone#: _____	
Exposure Information: <input type="checkbox"/> Sex <input type="checkbox"/> Needle Sharing <input type="checkbox"/> Other		First: _____	
		Last: _____                      Freq: _____	

Race: <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Other	Skin Complexion: _____
Facial Hair:    Beard                      Moustache                      Height: _____	Weight: _____
Identifying Information: (i.e. scars/tattoos)                      Hair Color: _____	Glasses: _____

Reporting Agency: _____	Site #: _____	Date: _____
Counselor: _____	Phone Number: _____	

Submit to:            Kevin F. Green  
Program Administrator, Counseling & Testing  
500 S. Broad St. 3rd Floor  
Philadelphia, PA 19146



**Exhibit 4 (Cont.)**

**Pretest Counseling/Observation  
Counselor Observation**

**Page 2**

10. Client was provided information on the following:

	Counselor	Video/Pamphlet	Not Provided
a. Purpose of the test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Meaning of results	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. AIDS prognosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Value of testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Condom use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please provide examples for questions #11-16.**

11. How well did the counselor provide information at a level of comprehension which was consistent with the client's age and learning skills? Explain.
  
12. How well did the counselor provide/demonstrate culturally competent messages, (e.g., provided in a style and format respectful of cultural norms)? Explain.
  
13. How linguistically appropriate was the counselor with the client, (e.g., presented in a dialect and terminology consistent with the clients native language and style of communication)? Explain.
  
14. How do clients schedule appointments to return for results at the time of the pretest session?
  
15. How well did the counselor reinforce the importance of returning for test results/counseling? Explain.
  
16. What and when is related paperwork completed by the counselor? Explain.

**Exhibit 4 (Cont.)**

**Counselor Observation**  
**Page 3**

**Observational Comments**

## Exhibit 4 (Cont.)

### COUNSELOR OBSERVATION

#### Post-Test Counseling

1. How long did the observed post-test counseling session last?
2. Did the counselor(s) introduce her/himself and explain the purpose of the session?  
Yes                      No
3. Did the counselors(s) use open-ended questions? (Give examples)  
Yes                      No
4. Did the counselor(s) ascertain if a personal risk reduction plan was established in the pretest session?  
Yes                      No
5. If yes to #4, did the counselor (check if "yes"):
  - a. reinforce successful efforts?
  - b. discuss failed efforts?
  - c. provide additional coaching on risks remaining?
6. If no plan had previously been established, did the counselor (check if "Yes"):
  - a. Negotiate a personalized, incremental risk reduction plan with the client(s), i.e. tailored to the behaviors, circumstances and special needs of the client(s) during the posttest session?
  - b. Deliver global prevention messages independent of the clients personal risk behaviors and circumstances?
  - c. Fail to discuss risk reduction in the post-test session?

If a risk reduction plan was discussed, was it revised or updated in the record or review in any subsequent retesting sessions?

Yes                      No

7. Did the counselor (s) (check if "yes")

Routinely recommend retesting at 3-6 months?

Recommend retesting if unsafe behaviors occurred within the last three months or should occur in the future?

Not discuss retesting?

**Exhibit 4 (Cont.)**

**Post-test Counseling/Observation  
Counselor Observation  
Page 2**

**OBSERVATIONAL COMMENTS (IF ANY):**

**Exhibit 4 (Cont.)**

**Attachment E**

City of Philadelphia  
Department of Public Health  
AIDS Activities Coordinating Office  
HIV Prevention Services Unit

**PREVENTION COUNSELING  
PROGRAM PROGRESS REPORT AGENCY**

Program/Activity

Report Period

Contract Period

AACO Funding for this Program

Funding Source

Report Submitted by

**Section I – Goals**

A.

- 1.
- 2.
- 3.
- 4.

B.

- 1.
- 2.
- 3.
- 4.

**Exhibit 4 (Cont.)**

**Section II – Progress in Meeting Goals**

A.

	Number Prevention Counseled	Number Counseled/ Not Tested	Number Tested	Number of Result Sessions	Number of Counselor/s Hours Worked
Site No.					
Site No.					
Site No.					
Site No.					
Site No.					
Totals					

B.

1.

a.

b.

2.

a.

b.

3.

a.

b.

## **Exhibit 4 (Cont.)**

### **Section III Accomplishments**

A. Programmatic

B. Administrative

C. Fiscal

### **Section IV – Challenges**

A. Programmatic

B. Administrative

C. Fiscal

**Exhibit 4 (Cont.)**

**Section V – Plan of Action to Meet Challenges in Section IV**

- A. Programmatic
  
- B. Administrative
  
- C. Fiscal

**Section VI – Collaboration**

*Please footnote all changes that relate to the addition or deletion of agencies with which you hold Letters of Agreement.*

- A. Names of agencies with Letters of Agreement on file and numbers of referrals:

Name	Number
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

- B. Other (specify):

Name	Number
1.	
2.	
3.	
4.	
5.	

**Exhibit 4 (Cont.)**

**EQUIPMENT INVENTORY FORM  
HIV Prevention Services  
AIDS Activities Coordinating Office  
Revised 11/95**

*Any equipment acquired with AACO funds, and a purchase price greater than \$500 should be entered below. This form should be submitted with the monthly invoice as the line item justification for that purchase.*

	Date Purchased	Equipment Description	Serial Number	Location
1.				
2.				
3.				
4.				
5.				

	Date Purchased	Equipment Description	Serial Number	Location
1.				
2.				
3.				
4.				
5.				

	Date Purchased	Equipment Description	Serial Number	Location
1.				
2.				
3.				
4.				
5.				

**Exhibit 5  
Attachment B**

**City of Philadelphia  
Department of Public Health  
AIDS Activities Coordinating Office  
HIV Prevention Services Unit**

**PROGRAM PROGRESS REPORT**

Program/Activity	Report Period
Contract Period	AACO Funding for this Program
Funding Source	Report Submitted by

**Section I – Goals**

A.

B.

- 1.
- 2.
- 3.
- 4.
- 5.

**Section II – Progress in Meeting Goals**

A.

B. Enter goals stated in Section I-B of this report:

**Section III – Accomplishments**

A. Programmatic

B. Administrative

C. Fiscal

**Exhibit 5 (Cont.)**

**INSTRUCTIONAL TEMPLATE  
City of Philadelphia  
Department of Public Health  
AIDS Activities Coordinating Office  
HIV Prevention Services Unit**

**Risk Reduction  
PROGRAM PROGRESS REPORT AGENCY  
(Enter agency name)**

Program/Activity  
(Enter name of program or activity  
for this contract)

Report Period  
(Enter month being reported on)

Contract Period  
(Enter start and end dates)

AACO Funding for this Program  
(Enter dollar amount of contract/s)

Funding Source  
(Enter source, indicate City, State, or  
Federal completing)

Report Submitted by  
(Enter name of individual  
responsible for the report)

**Section I – Goals**

- A. (Enter Section II part A of contract service provisions)
- B. (Enter goals that have been established with AACO Program Analyst)

- 1.
- 2.
- 3.
- 4.
- 5.

**Section II – Progress in Meeting Goals**

- A. (Enter statistics for the month using the table/s provided)

## **Exhibit 5 (Cont.)**

### **Program Progress Report**

B. Enter the goals stated in Section I-B of this report:

1. (Enter goal)
  - a. (Enter work statement/s)
  - b. (Enter progress and/or barriers to implementing work statement/s)
2. (Enter goal)
  - a. (Enter work statement/s)
  - b. (Enter progress and/or barriers to implementing work statement/s)
3. (Enter goal)
  - a. (Enter work statement/s)
  - b. (Enter progress and/or barriers to implementing work statement/s)
4. (Enter goal)
  - a. (Enter work statement/s)
  - b. (Enter progress and/or barriers to implementing work statement/s)
5. (Enter goal)
  - a. (Enter work statement/s)
  - b. (Enter progress and/or barriers to implementing work statement/s)

### **Section III – Accomplishments**

*(Enter overall accomplishments, excluding statistics mentioned in Section II A and achievements mentioned in Section II B):*

- A. Programmatic
- B. Administrative
- C. Fiscal

### **Section IV-Challenges**

*(Enter overall challenges, excluding difficulties stated in Section II):*

- A. Programmatic
- B. Administrative
- C. Fiscal

## Exhibit 5 (Cont.)

### Section V – Plan of Action to Meet Challenges in Section IV (Enter plan)

- A. Programmatic
- B. Administrative
- C. Fiscal

### Section VI – Collaboration

*(Enter the number of referrals made to agencies of which you hold Letters of Agreement. Agencies with Letters of Agreement should become permanent entries.)*

Please footnote all changes that relate to the addition or deletion of agencies with which you hold Letters of Agreement.

- A. Names of agencies with Letters of Agreement on file and numbers of referrals:

(Enter name of agency)

(Enter number of referrals)

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

- B. Other (specify):

(Enter name of agency)

(Enter number of referrals)

- 1.
- 2.
- 3.
- 4.
- 5.

**Exhibit 5 (Cont.)**

**Attachment C  
EQUIPMENT INVENTORY FORM  
HIV Prevention Services  
AIDS Activities Coordinating Office  
Revised 11/95**

*Any equipment acquired with AACO funds, and a purchase price greater than \$500 should be entered below. This form should be submitted with the monthly invoice as the line item justification for that purchase.*

	Date Purchased	Equipment Description	Serial Number	Location
1.				
2.				
3.				
4.				
5.				

	Date Purchased	Equipment Description	Serial Number	Location
1.				
2.				
3.				
4.				
5.				

	Date Purchased	Equipment Description	Serial Number	Location
1.				
2.				
3.				
4.				
5.				

## Exhibit 6

### HOTLINE CALL RECORD - FY 97

Data entry use only:

Prep By \_\_\_\_\_ Date \_\_\_\_\_ Time: Start \_\_\_\_\_ Finish \_\_\_\_\_

#### CALL MADE BY GENDER

- |                        |                  |
|------------------------|------------------|
| 1. Consumer            | 1. Female        |
| 2. Friend/partner/rel. | 2. Male          |
| 3. Hospital/clinic     | 3. Mixed group   |
| 4. Agency              | 4. Transgendered |
| 5. School              | 5. Unknown       |

#### INSURANCE

1. MA/SSI
2. Military/VA
3. Employer/Private
4. None
5. Unknown

#### RACE/ETHNICITY

1. African-American
2. Caucasian
3. Hispanic/Latino
4. Asian-American/  
Pacific Islander
5. Native American/Aleutian/  
Native Alaskan/Eskimo
6. Other
7. Unknown
8. N/A
9. Refused

#### AGE \_\_\_\_\_

1. Mixed Group
2. Unknown
3. Refused

#### 6. CHOICE Counselor

7. Other

6. N/A

7. Refused

1. Advocacy
2. Call in Spanish
3. Call in other language
4. TTY

PA COUNTY  
CODE \_\_\_\_\_

#### ZIP CODE \_\_\_\_\_

1. Outside of Phila. Metro area
2. Unknown

#### SUBJECT

- |                             |                |                                       |                                 |
|-----------------------------|----------------|---------------------------------------|---------------------------------|
| 1. Abortion                 | M              | Teen Access                           | 8. Financial assistance/MA      |
| 2. Abuse                    | A. Rape        | D. Parental consent                   | 9. Food/shelter                 |
| 3. Adoption                 | B. Incest      | E. Out-of-state                       | 10. General health              |
| 4. Birth control            | C. Life-threat | F. Court-bypass                       | 11. Gyn                         |
| A. Cervical cap             |                | G. Undecided                          | 12. Infertility                 |
| B. Depo Provera             |                |                                       | 13. Healthy Start               |
| C. Diaphragm                |                | Abortion/Prenatal Care/<br>Pregnancy: | 14. HIV/AIDS *                  |
| D. Female condom            |                | H. First trimester                    | 15. Legal/legislative           |
| E. Foam                     |                | I. Second trimester                   | 16. Menstruation cycle          |
| F. IUD                      |                | J. Third trimester                    | 17. Pregnancy/childbirth        |
| G. Male condom              |                | K. Unknown                            | 18. Pregnancy options           |
| H. Norplant                 |                | L. N/A                                | 19. Pregnancy support/parenting |
| I. Pills                    |                |                                       | 20. Pregnancy test/symptoms     |
| J. Post-Coital pill         |                |                                       | 21. Prenatal care               |
| K. Sponge                   |                |                                       | 22. Sexuality                   |
| L. Natural FP/CMBBT         |                |                                       | 23. STD/infection               |
| 5. Counseling/mental health |                |                                       | 24. Sterilization               |
| 6. Drug abuse               |                |                                       | 25. Other                       |
| 7. Education/job training   |                |                                       |                                 |

## HIV/AIDS

Type of Call	Consumer's Status	Consumer's Concerns			
1. Case management	6. Symptoms	A. HIV	1. Blood transfusion/products	6. Pediatric	
2. General Info	7. Testing	B. HIV+asymptomatic	2. Caregiver/partner	7. Sexual	A. F/M
3. Housing	8. Transmission	C. HIV+ symptomatic	3. Casual contact	8. Work related	B. M/M
4. Medical care	9. Treatment	D. AIDS	4. Health care related	9. Other	C. F/F
5. Support/counseling	10. Other	E. Unknown	5. IDU	10. Unknown	D. Unknown
	F. N/A	11. N/A	E. N/A		

## HOW HEARD OF HOTLINE

1. Called before	7. Other outreach/materials	13. SEPTA car card	19. Campaign E
2. Friend/relative/partner	8. Newspaper ad/coverage	14. Healthy Start Campaign	20. Unknown
3. Agency	9. Radio ad/coverage	15. Campaign A	21. Other
4. Hospital/clinic	10. TV ad/coverage	16. Campaign B	22. N/A
5. Private Practitioner	11. Phone book/information	17. Campaign C	
6. CHOICE outreach/ materials	12. School	18. Campaign D	

## NUMBER CALLED

1. 985-3300	5. 1-800-84-TEENS	1. FPC
2. 985-AIDS	6. Other	2. MCH
3. 1-800-985-AIDS	7. Transfer from	
4. 1-800-876-MOMS	8. 1-800-662-6080	

## FUNDING SOURCE

4. AACO	6. Other Non-Funded
5. Ryan White	
3. Abortion/adoption	
7. AIDS Fact Line	

## REFERRAL SUMMARY

**Exhibit 7**

**ATTACHMENT A**

AGENCY: \_\_\_\_\_

PROGRAM: \_\_\_\_\_

FUNDING SOURCE: FORMULA ( ) SUPPLEMENTAL ( )

CONTRACT PERIOD: \_\_\_\_\_

PROGRAM ANALYST: \_\_\_\_\_

AACO MONTHLY DATA FORM

FOR THE MONTH OF  
(one month only)

*PLEASE COMPLETE THE FOLLOWING INFORMATION FOR EACH TYPE OF UNIT OF SERVICE YOU PROVIDE. PLEASE USE ONE SHEET FOR EACH SERVICE UNIT IDENTIFIED IN YOUR SERVICE DESCRIPTION PAGE. PLEASE DO NOT REVISE THIS FORM.*

SERVICE UNIT TYPE: \_\_\_\_\_

1. Number of units of service provided this month (current contract period): \_\_\_\_\_

2. Number of new unduplicated clients provided this service this month: \_\_\_\_\_  
(a. clients not previously reported. A new client is an individual who received services from a particular provider for the first time ever. A person can be new to a provider only once. Clients who receive no services for a time, or clients who are considered deactivated by the provider, should not be reported as new every time they return or are reactivated. A provider should determine whether clients are old or new with readily available information. It is not expected to retrieve archived records or take other unreasonable measures.)

3. Total number of unduplicated clients provided this service this month: \_\_\_\_\_

4. Number of unduplicated clients provided this service from the start of the contract period through the month being reported: \_\_\_\_\_

**Exhibit 7 (Cont.)**

**ATTACHMENT B  
RYAN WHITE TITLE I QUARTERLY NARRATIVE REPORT**

Providers who receive Title I Formula and Supplemental funding as well as City funding for AIDS treatment services (home health, case management, transportation, etc.) through the AIDS Activities Coordinating Office, must complete this narrative report on a quarterly basis. The reporting quarters run on a calendar year schedule, i.e. January through March, April through June, July through September and October through December. PLEASE COMPLETE A SEPARATE FORM IN CONNECTION WITH EACH TITLE I FORMULA, SUPPLEMENTAL AND CITY FUNDED AIDS TREATMENT SERVICE CONTRACT THAT YOU RECEIVE THROUGH AACO. Do not complete this form in connection with CDC funded Prevention/Education contracts your agency may receive through AACO.

**AGENCY NAME:**

**PROGRAM:**

Year 07 Amount: \_\_\_\_\_ Funding Source: Formula \_\_\_\_\_  
Supplemental \_\_\_\_\_  
City General \_\_\_\_\_

1. Briefly describe the services offered by this program during the past quarter. Describe the target population(s) served by this contract and how this program has met the needs of this population. For the first report of this contracts fiscal year (i.e. for Supplemental - April through June and Formula - January through March), indicate the program's annual goals. Subsequent quarterly reports should indicate any AACO pre-approved changes made to this program's annual goals and the reason(s) for same.

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2. Describe the progress made by this program in meeting its annual goals during the past quarter. Please include the number of unduplicated clients served and the number of service units (case management encounters, visits, trips, etc.) provided to those clients. In some cases your program may have multiple service units. You should refer to your AACO service provisions as well as the AACO Monthly Data Forms in connection with this program in completing this section. If this program did not meet its service goals during the past quarter, please indicate the reason(s) and describe corrective steps either planned or being implemented.

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3. If the services offered by this program are Medicaid eligible (i.e. case management, primary medical care, home health, dental and nutritional counseling) indicate a) how many of the reported unduplicated clients who received services during the quarter (indicated in question #2 above) were Medicaid eligible and b) how many of these Medicaid eligible clients reported in #3a received this service funded by Medicaid or Health Choices?

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**Exhibit 7 (Cont.)**

- 4. a) Briefly discuss any significant barriers that your program has experienced in the provision of this service to your clients, problems encountered in delivering services and unmet needs.

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- b) Describe how this program has worked to overcome the barriers indicated above. Also, indicate any actions that were taken or plans formulated to respond to these areas of concern.

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- 5. Describe technical assistance needs this program has identified.

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- 6. Describe any changes in staff funded by this contract during the past quarter (i.e. has anyone been hired, fired, promoted). Indicate if new job titles were created. Provide job descriptions as appropriate.

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- 7. Describe any organizational budget changes in the last quarter that affect the delivery of services in this contract.

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- 8. Discuss trends and share insight regarding demand/needs that affect or may affect the provision of this program's services from your organization's point of view. Provide documentation as appropriate.

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- 9. Indicate any significant programmatic accomplishments/highlights relevant to the quarter.

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10. Indicate the level of involvement and participation of Persons With HIV/AIDS in the design and delivery of Title I funded services both at your agency and with regard to this particular program. Please be as specific as possible (i.e. indicate the number of consumers who are involved in the delivery of Title I services, the number of paid versus volunteer HIV consumer staff, support groups conducted by and for Persons With HIV/AIDS, HIV consumer needs assessments conducted by your agency, etc.). Please indicate how your agency and/or this program documents HIV consumer involvement.

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11. Indicate any mechanisms/ processes in place at your agency which allows for the assessment of Title I funded services by Persons With HIV/AIDS.

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**Exhibit 7 (Cont.)**

**STANDARD ANNUAL ADMINISTRATION REPORT**

**CONTACT INFORMATION**

Provider Name (line 1 of 2):

\_\_\_\_\_

Provider Name (line 2 of 2):

\_\_\_\_\_

Address (line 1 of 2):

\_\_\_\_\_

Address (line 2 of 2):

\_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Title:

\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

2. Provider Number: \_\_\_\_\_

3. Reporting Period (Month/Day/Year):  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ through \_\_\_\_/\_\_\_\_/\_\_\_\_\_

4. Zip Code of Principal Site: \_\_\_\_\_

5. Total Number of Provider Sites: \_\_\_\_\_

6. Provider Type (circle one):
- (01) Hospital or hospital-based clinic
  - (02) Public-funded community health center
  - (03) Public-funded community mental center
  - (04) Other community-based service organization
  - (05) PWA coalition
  - (06) Health department
  - (07) Other public agency
  - (08) Solo/group private health practice
  - (09) Other
  - (99) Unknown

7. Ownership Status (circle one):
- (01) Public/local
  - (02) Public/state
  - (03) Public/federal
  - (04) Private/nonprofit
  - (05) Private/for profit
  - (06) Unincorporated
  - (99) Unknown

8. Do members of minority racial/ethnic groups constitute a majority of Board members and/or a majority of staff (volunteer or paid) providing care? (circle one)
- (1) Yes      (2) No      (9) Unknown

### STANDARD ANNUAL ADMINISTRATIVE REPORT (Cont.)

Total Number of Clients (nnn,nnn = number, 999,999 = unknown)

9.	Total Unduplicated Number of Clients Served During Reporting Period	
10.	Number of New Clients	
11.	Number of Clients Without Client-Level Information (anonymous, drop-in)	
12.	Number of clients who are:	Male
		Female
13.	Number of Clients who are: Black (Non-Hispanic)	White (Non-Hispanic)
		Hispanic
		Asian/Pacific Islander
		American Indian/Aleutian/Native Alaskan/Eskimo
14.	Number of clients who are:	Under 13 Years of Age
		13-19 Years of Age
		Age 20 and Over
15.	(Medical Providers only) Estimated % of Adult/Adolescent Clients by exposure category: 999.9 = Unknown	Men who have sex with men
		Injection Drug Use (IDU)
		Men who have sex with men AND IDU
		Heterosexual contact
		Other/Undetermined
16.	HIV/AIDS Status: 999.9 = Unknown	Estimated % of clients who have HIV (non-AIDS)
		Estimated % of clients with an AIDS diagnosis

17. Total Office-Based Health Service Contacts this Reporting Period  
 (0= no contacts but deliver service; nn,nnn,nnn = number contacts;  
 99,999,998 = not applicable, does not deliver service; 99,999,999 = unknown)

	Medical care visits
	Dental care visits
	Mental health treatment/therapy/counseling visit
	Substance abuse treatment/counseling visits
	Rehabilitation services

18. Case Management Encounters  
 (0= no contacts but deliver service; nn,nnn,nnn = number contact;  
 99,999,998 = not applicable, does not deliver service, 99,999,999 = unknown)

	Face to face encounters
	Other encounters

19. Home Health Care Visits  
 (0 = no visits but deliver service; nn,nnn,nnn = number visits;  
 99,999,998 = not applicable, does not deliver service; 9,999,999 = unknown)

	Paraprofessional (4 hours = 1 visit)
	Professional (2 hours = 1 visit)
	Specialized (2 hours = 1 visit)

**Exhibit 7 (Cont.)**

**STANDARD  
ANNUAL ADMINISTRATIVE REPORT (CONT.)**

20. Number of HIV/AIDS Clients who Received these Services:  
 (0 = no contacts but deliver service; n,nnn,nnn = number contacts;  
 9,999,998 = not applicable, does not deliver service; 9,999,999 = unknown)

_____	Residential hospice	_____	Housing assistance
_____	In-home hospice	_____	Food bank/home
_____	Buddy/companion	_____	Delivered meals
_____	Client advocacy	_____	Transportation
_____	Other counseling	_____	Education/risk reduction
_____	Day or respite care	_____	Foster care/adoption
_____	Emergency financial assistance	_____	Other services

21. HIV/AIDS Funding (for HIV/AIDS clients):  
 (nnn,nnn,nnn = actual dollar amount; 999,999,998 = not applicable; 999,999,999 = unknown)

_____	Title I CARE	_____	State/local public sources (other than than Medicaid)
_____	Title II CARE	_____	Other sources (fund-raising, contributions,etc.)
_____	Title III CARE	_____	Other Federal Funding
_____	Section 329, 330, 340		
_____	HIV Pediatrics Demonstration Projects, other Federal Pilots		

22. Expenditures for HIV/AIDS Related Services  
 (nnn,nnn,nnn = amount spent; 999,999,998 = not applicable; 999,999,999 = unknown)

_____	Direct service staff	_____	Other direct
_____	Medications	_____	Total Expenditures
_____	Contracted services		

23. Staffing  
 (000.0= applicable but no FTEs; nnn.n = number FTEs; 999.9 = not applicable)

Total paid staff in full-time equivalent	_____	Total volunteer staff in full-time equivalents	_____
--	-------	--	-------

24. Staff Added  
 Were Title I and/or Title II CARE funds used to add any paid staff? (circle one for each category)

Physicians (1) Yes (2) No (9) Unknown	Licensed mental health staff (1) Yes (2) No (9) Unknown
Nurses, physician assistants, nurse practitioners (1) Yes (2) No (9) Unknown	Case Managers (1) Yes (2) No (9) Unknown
Dentists (1) Yes (2) No (9) Unknown	Clerical/support staff (1) Yes (2) No (9) Unknown

**Exhibit 7 (Cont.)  
Attachment D**

**CITY OF PHILADELPHIA**

DEPARTMENT OF PUBLIC HEALTH  
500 S. Broad Street – 2nd Floor  
Philadelphia, PA 19146  
ESTELLE B. RICHMAN  
Health Commissioner  
JESSE MILAN, JR., ESQ.  
Director  
AIDS Activities Coordinating Office

March 13, 1997

Dear Title I Provider:

I am writing to inform you that federal Health Resources and Services Administration (HRSA) guidelines require your agency to have procedures and internal controls in place to document and ensure that all clients receiving Title I funded services are "eligible beneficiaries." Eligible beneficiaries are Persons with HIV/AIDS and their families.

This mandatory documentation applies to all Ryan White funded services with only limited exceptions (for example, services to non-HIV infected family members or anonymous services).

Consistent with HRSA mandates, AACO requires the following of all service providers who receive Ryan White Title I funds in the nine county Philadelphia planning region:

- 1) The Ryan White provider should ensure that confidential primary documentation of a client's positive HIV serostatus is included in the client's file. This documentation must be in the form of either a lab test result issued by the testing laboratory or a physician's certification.
- 2) In cases where referrals are made for Ryan White funded services, other than case management or primary care, from another Ryan White funded provider, it is not necessary for the agency providing the new service to maintain HIV status documentation in the client's file. Rather, the referring Ryan White agency will maintain this information. The client file located at the site providing the service must contain a reference to this HIV documentation at the referring site. This will be either in the form of a certified referral form (signed and on agency letterhead) or a notation that such eligibility has been confirmed, including the name of the person and organization verifying eligibility, date, nature and location of primary documentation.
- 3) As stated above, where it is appropriate for a Ryan White agency to provide services to HIV-affected clients, it is the responsibility of the provider to maintain documentation in each client's chart as to the client's relationship to a Person With HIV/AIDS.

Your assigned AACO Program Analyst, during an upcoming site visit, will check client files to verify that the above referenced documentation is maintained by your agency.

If you have any further questions concerning this matter, please contact John Cella, Administrator for Ryan White Title I programs, or your assigned AACO Program Analyst.

Once again, thank you for your interest in this most important matter.

Sincerely,

Estelle B. Richman  
Health Commissioner  
EBR/d  
cc: John Cella

## **SECTION 6200**

### **COORDINATING OFFICE FOR DRUG AND ALCOHOL ABUSE PROGRAMS**

#### **Section 6201 - General Information**

- .01 The Coordinating Office for Drug and Alcohol Abuse Programs (CODAAP) is a component of the Philadelphia Department of Health, and also serves as the single county authority for the County of Philadelphia reporting to the State Office of Drug/Alcohol Abuse Programs. Acting in these dual capacities, CODAAP has a broad range of responsibilities which fall into the general categories of planning, funding, monitoring and coordination. Under the category of planning, CODAAP's efforts result in the preparation of a three year plan which is updated annually. This plan details local efforts to address all aspects of the citywide campaign against substance abuse. Based upon the priorities established in the plan, CODAAP allocates federal, state and local resources to service providers within the City. It also monitors these service providers against service projections and budgets established at the beginning of each fiscal year, and federal, state, and local standards/regulations. The provision of program and fiscal management technical assistance, as well as the dissemination of information concerning additional available funding sources for the expansion of treatment/prevention programs, are also responsibilities of the office. Another responsibility of CODAAP, is the liaison function it provides between contract programs and federal/state funding and regulatory agencies.
- .02 In addition to its overall management responsibilities, CODAAP is engaged in a number of more direct activities. CODAAP provides and/or arranges training for provider agency staff and medical and human services professionals, as well as educational activities for the general public. It arranges for speakers and educational materials for community meetings, health fairs, special programs, and other educational activities. It provides and distributes educational materials to agencies, organizations, and the general public, and publishes a Resource Guide to D&A services available in the Philadelphia area. It also publishes the CODAAP REPORT, a newsletter for drug/alcohol treatment and prevention professionals.

#### **Section 6210 - Program Descriptions and Operations**

- .01 CODAAP provides the following types of program services.
- .02 Treatment Services:
- Treatment services supported by CODAAP include outpatient counseling and therapy, methadone maintenance, residential treatment programs, and detoxification. More than 50 facilities located throughout the city deliver these services to almost 18,000 clients a year, nearly 7,500 at any given time.
- .03 Prevention Services:
- CODAAP supported prevention services reach more than 120,000 students and citizens in Philadelphia each year. These prevention services are both school and community-based.
- School-based programs include the presentation of a drug and alcohol prevention curriculum in the lower grades, a small group problem-solving approach in the middle grades, and more intensive peer counseling at the high school level. These services are provided in more than 80 public and parochial schools in all areas of the city.
- .04 Community-based services include presentations and workshops for parents, residents of housing projects, church groups, and recreation centers, etc.
- .05 The above noted CODAAP operations are funded through potential providers via a contract award which may be either program funded or fee-for-service funded. The following briefly describes those funding mechanisms:

## Section 6210 (Cont.)

- Program funded projects are privately administered and staffed and are reimbursed for their total personnel, operating and fixed asset expenses as predetermined by the City of Philadelphia.
- CODAAP less all interest or other incomes derived by the Agency from the use of agreement funds.
- Fee-for-service are service providers which are privately administered, staffed and partially funded by a contracted per diem or fee rate by the City of Philadelphia - CODAAP.

## Section 6220 - Federal CFDA Numbers/Other Regulations

.01 The following federal CFDA numbers are applicable to CODAAP programs:

<u>Reference</u>	<u>CFDA Number</u>	<u>Formal Reference</u>
PENN DOT	20.600	State and Community Highway Safety Program
ADAMH	93.959	Alcohol & Drug Abuse Mental Health Block Grant
OSAP	93.194	Office of Substance Abuse Prevention
Family Preservation	93.667	Social Services Block Grant
Governor's Discretionary Fund	84.186	Governor's Discretionary Fund
Drug Abuse Improvement	93.196	Targeted Cities

.02 In addition to the above the auditor should be familiar with the following document:

- Fiscal Management Guidelines for County Drug and Alcohol Programs.
- Fiscal Federal Block Grant Regulations.

## Section 6230 - Program Compliance Procedures

.01 As discussed in Sections 300 and 500 of this Audit Guide, each City of Philadelphia Department program has specific auditing requirements. These requirements are in addition to those areas of audit specified in Sections 300 and 500 of this Guide. The audit requirements listed on the following pages are not all inclusive and do not represent an audit program for conducting a financial and compliance audit of the program(s). The audit requirements listed are presented as highlights of areas of special interest to the Department. Any deficiencies noted as a result of the procedures are to be disclosed in the Schedule of Findings and Questioned Costs

.02 Service objective projection and implementation are integral parts of the CODAAP contracting process. Each year prior to the allocation of funds, CODAAP contract programs must submit a set of service projections estimating the number of services they will provide to clients during the year. Some of the data an agency may report to CODAAP could be, for example, the number of residential days, number of counseling hours, methadone visits, and school presentations. CODAAP program staff review this information as to its propriety, and programs are instructed to change projections in cases where over or under projecting is identified.

.03 During the year, approximately 10 working days following the end of each quarter, programs are required to submit reports to CODAAP indicating their progress in meeting their projections. In cases where a ten percent (10%) deviation from what was projected is evident, programs must submit a written narrative explaining the deviation.

.04 As service objective reporting constitutes such an important aspect in CODAAP's efforts to test the viability of the service system, it is expected that the auditor solicit from each contract agency answers to the following questions, and include any deficiencies noted as a compliance finding in any final audit report:

- How does the program collect its quarterly service objective implementation information? Indicate which staff are involved, the data used in this process, and describe.
- Determine the process used by the program to check the accuracy/validity of the quarterly service objective reports to CODAAP. If no validation process is used, determine why not and report upon.
- What steps does the program take to address consistent patterns of under implementation/over implementation of projected service objectives? What staff are involved in this process? How are they involved?

## **Section 6230 (Cont.)**

- .05 Copies of the service objective forms used by CODAAP and their instructions for completion are included as Exhibits 1 to 6.

## **Section 6240 - Financial Compliance Procedures**

- .01 As discussed in Sections 300 and 500 of this Audit Guide, each City of Philadelphia Department program has specific auditing requirements. These requirements are in addition to those areas of audit specified in Sections 300 and 500 of this Guide. The audit requirements listed on the following pages are not all inclusive and do not represent an audit program for conducting a financial and compliance audit of the program(s). The audit requirements listed are presented as highlights of areas of special interest to the Department. Any deficiencies noted as a result of the procedures are to be disclosed in the Schedule of Findings and Questioned Costs.
- .02 The financial and compliance procedures for CODAAP are provided on the following pages based upon two types of program services:
- a. Program Funded Projects (Section 6240.03 to 6240.07)
  - b. Fee-for-Service Projects (Section 6240.08 and 6240.09)

### **Program Funded Projects**

#### **Revenues:**

- .03 Program-funding is the most common method employed by CODAAP to fund its provider agencies. This method allows CODAAP to fund a provider agency's actual eligible expenditures for a provider agency's service(s), offsetting these expenses by anticipated revenues to be received directly by the provider, and establishing the remaining deficit as its authorized level of funding (allocation). Reimbursement is affected on a "last-dollar-in" basis and is based upon actual eligible expenses incurred less actual revenue generated, up to the maximum contract funding.
- .04 Audit procedures should include the following:
- Does the Agency have a system in place to adequately account for all applicable income received or earned by the agency and that such income was properly reported to CODAAP.
  - That medical assistance billings for the program are fully recorded and that re-billings are submitted on claims which have been denied for payment.
  - That medical assistance payments are recorded on the accrual basis recognizing any applicable reserves for uncollectible amounts (after pursuing all means of collecting on payments as discussed above).

#### **Expenditures:**

- .05 The Agency reports expenses to CODAAP in Section III of Form 311 "Year-To-Date Fiscal Report and Cash Request" (Exhibit 7). This report breaks down the expenses into personnel services, operating expenses, and fixed assets. The auditor should utilize this report as the basis of determining the appropriateness of amounts reported to CODAAP and to develop audit procedures to test these expenses. The audit procedures developed are to include, at a minimum, appropriate procedures from Section 300 of the Guide, required compliance matters from the Fiscal Management Guidelines for CODAAP, and consider the following items:
- Personnel costs charged to the program as reported to CODAAP on the Personnel Roster Report are appropriate, properly supported and allocations of time are documented.
  - Administrative overhead costs appear reasonable and are based upon a documented allocation plan. The auditor should consider appropriate procedures from Section 300 - Indirect Costs.
  - Capital expenditures or depreciation expense are not eligible for reimbursement.
  - Items charged to rent expense are in fact only for building rent expense and do not include any use charges in lieu of rent. Additionally, that rent expense charged by a related party be examined for reasonableness based upon comparable space at current market prices. The related party transaction must be disclosed in the notes to the financial statements in accordance with Financial Accounting Standards Board requirements (SFAS No. 57).

## **Expenditures: (Cont.)**

- Interest expense charged to the program is only due to temporary loans the Agency had to obtain to cover cash flow deficiencies due to lack of timely payments from CODAAP.

## **Budget Modifications:**

.06 The contract between CODAAP and the Agency contains a clause, labeled Budget and Service Modifications, which states the following:

"Changes in AGENCY's program budget and Service Objectives may be authorized by CITY where such changes are the result of a written request, with supporting documentation, submitted to and approved by the Director of CODAAP. AGENCY shall make no such changes prior to its receipt of written approval by said Director. Said budgets and Service Objectives will be maintained in an AGENCY file kept by CITY. All final requests for budget and/or Service Objective modifications, with supporting justification, shall be submitted to CITY by April 1st for approval. Budget and/or Service Objectives revisions will not be reviewed unless supporting justification is provided. Failure to comply with the provisions of this paragraph may result in non-reimbursement of expenses resulting from such modifications."

.07 Based upon the above the auditor should determine that:

- The budgetary amounts reported in Section III of the Year-To-Date Fiscal Report and Cash Request are the final amounts approved, including any modifications.
- If applicable, the Agency has followed the modification process as detailed above.

## **Fee-for-Service Projects**

### **Revenues:**

.08 Revenues for a fee-for-service funded program are based upon a set fee or rate of reimbursement for each authorized unit of service rendered by the provider agency to eligible clients. The agency invoices CODAAP on a monthly basis, by client, for such services on Form 310 - Fee-for-Service Invoice/Report (Exhibit 8a).

The fee-for-service type of funding requires special types of audit tests, since there are no expenses reported to CODAAP. The auditor is to determine the appropriateness of the units billed, the units of service actually provided and any offsetting revenue earned.

.09 Audit procedures should include the following:

- Does the agency have a system in place which accumulates the units of service by client and by type. In addition, are third party revenues maximized prior to billing those units to CODAAP.
- Obtain from the Agency a Summary of Services Billed by Type (this will be utilized in the audit report - see Supplemental Financial Statements Section 6250) for the audit period.
- Determine appropriateness of units of service billings to CODAAP by testing that:
- Service units reported on Form 310 are supported by agency and client records and that the units agree in amount, type of service, date service was rendered, and were adjusted appropriately for any third party (non-CODAAP) revenue.
- Rate per unit billed to CODAAP is appropriate after all deductions have been made for first and/or third party revenues.

## Section 6250 - Supplemental Financial Schedules and Reports

.01 The organization's audit report must include the following supplemental financial schedules, for each City of Philadelphia contract with \$300,000 or more of expenditures in addition to the financial statements as specified in Sections 400 and 500 of this Audit Guide. A designation has been made for those supplemental schedules required for a "single audit" report (Section 400) or a "program audit" report (Section 500). The auditor will be required to issue an opinion on the Supplemental Schedules listed below as specified in Section 400 of this Audit Guide.

.02 The supplemental financial schedules for a program funded and a fee-for-service project, are as follows:

### Program Funded Project

Supplemental Financial Schedule	Section Ref. to Sample Format	Single Audit Report	Program Audit Report
- Statement of Functional Expenditures by Contract/Program and Revenues by Funding Source (1)	6250.03	Yes	No (3)
- Reconciliation of Agency Reported Expenditures/Revenues to Audited Expenditures/Revenues (2)	6250.04	Yes	Yes

### Explanatory Notes:

(1) Statement will present expenditures by cost center and revenues by category type as reported and utilized in Form 311 - Year-to-Date Fiscal Report and Cash Request. A separate financial reporting for each CODAAP award must be presented. In addition, the supplemental financial statement must detail the costs by budget cost category and type of revenue. Combining multiple CODAAP awards in one financial statement is not acceptable.

(2) The statement must present expenditures and revenues as reported to CODAAP, report any additional accruals and other adjustments to reconcile the amount reported on the Statement of Functional Expenditures by Contract/Program and Revenues by Funding Source. The reconciliation schedule is required only for those contracts where the amounts reported by the agency to CODAAP differ from the final audited amounts. An explanation of any "other adjustment" must be provided. The accrual explanation, at a minimum, should indicate the type of expense accrued.

The explanation(s) to "other adjustments", however, must be detailed by the type of expense category, and then totaled by cost center.

(3) The statement of revenues and expenditures should contain the captions provided in the sample report format.

### Fee-for-Service Projects

Supplemental Financial Schedule	Section Ref. to Sample Format	Single Audit Report	Program Audit Report
- Statement of Units of Service and Program Revenue	6250.05	Yes	Yes

**Explanatory Note:**

(4) The statement is to present the following information for each individual type of CODAAP Fee-for-Service Award.

- The total units of service per the audit would represent the units reported by the subrecipient to CODAAP, net of any adjustments the auditor determines appropriate based upon his/her audit of the units of service billed. Where the audited units of service reflected on this statement differ from the total reported by the subrecipient, the auditor must provide on this schedule or on a following page the explanation of the difference with the amount adjusted.
- The approved unit rate is that unit rate by type of service reflected in the contract between the subrecipient and CODAAP.
- The gross cost is the result of multiplying the total units of service per audit by the approved unit rate.
- The program income is that income applicable to the particular program service. The details of the program revenue by type of service must be provided in the "Detail of Program Revenue" section of the statement.
- The net billing per audit is the result of subtracting the program revenue from the gross cost.

The above statement format is required for each unit of service award the subrecipient has entered into with CODAAP. A separate statement for each CODAAP award is to be presented, therefore, combining more than one CODAAP contract on a statement is not acceptable.

**Section 6250.03**

**ABC NOT-FOR-PROFIT CORPORATION  
 COORDINATING OFFICE FOR DRUG AND ALCOHOL ABUSE PROGRAMS  
 CITY OF PHILADELPHIA CONTRACT NUMBERS XX-XXXX AND XX-XXXX  
 STATEMENT OF FUNCTIONAL EXPENDITURES BY CONTRACT/PROGRAM  
 AND REVENUES BY FUNDING SOURCE (1)  
 JULY 1, 19XX to JUNE 30, 19XX**

	(1) Outpatient Services XX-XXX	(1) Women's Program XX-XXXX
Expenditures by cost center:		
Total Personnel Services	\$ xxxxx	\$ xxxxx
Total Operating expenses	xxxxx	xxxxx
Total Fixed assets	xxxxx	
Total expenditures by cost center	xxxxx	xxxx
Funding sources:		
Client fees	xxxxx	
City of Philadelphia, Coordinating Office for Drug and Alcohol Abuse	xxxxx	xxxx
Medical assistance fees, Commonwealth of Pennsylvania	xxxxx	
Total funding	xxxxxxx	xxxx
Excess of expenditures over funding sources	\$ xxxxx	\$ xxx

(1) A separate statement of expenditures and revenues must be provided separately for each CODAAP contract. Therefore, if an agency has five contracts the above schedule will have five separate financial amount columns, or five separate financial statements, one for each CODAAP contract.

**Section 6250.04**

**ABC NOT-FOR-PROFIT CORPORATION  
 COORDINATING OFFICE FOR DRUG AND ALCOHOL ABUSE PROGRAMS  
 CITY OF PHILADELPHIA CONTRACT NUMBER XX-XXXX  
 RECONCILIATION OF AGENCY REPORTED EXPENDITURES/REVENUES  
 TO AUDITED EXPENDITURES/REVENUES  
 JULY 1, 19XX to JUNE 30, 19XX**

	Amount Reported on Fiscal Report	(A) Other Adjustments	(B) Amount per Audit
Outpatient Services			
Expenditures by cost center:			
Total personnel services	\$ xxxxx	\$ (xx)	\$ xxxxx
Total operating expenses	xxxx	(xx)	xxxxx
Total fixed assets	xxxx		xxxx
Total expenditures by cost center	xxxxx	(xx)	xxxxx
Funding sources:			
Client fees	xxxxx		xxxxx
City of Philadelphia, Coordinating Office for Drug and Alcohol Abuse	xxxxx		xxxxx
Medical assistance fees, Commonwealth of Pennsylvania	xxxxx	xxxxx	
Total funding	xxxxxxx	xxx	xxxxxxx
Excess of expenditures over funding sources	\$ xxxxx	\$ xx	\$ xxxxxx

(A) See following page for explanation of adjustments.

(B) Amount funded under contract in accordance with CODAAP fiscal guidelines.

**Section 6250.04 (Cont.)**

**ABC NOT-FOR-PROFIT CORPORATION  
 COORDINATING OFFICE FOR DRUG AND ALCOHOL ABUSE PROGRAMS  
 CITY OF PHILADELPHIA CONTRACT NUMBER XX-XXXX  
 RECONCILIATION OF AGENCY REPORTED EXPENDITURES/REVENUES  
 TO AUDITED EXPENDITURES/REVENUES (CONT.)  
 July 1, 19XX to June 30, 19XX**

**Explanation of Other Adjustments:**

Budget Category	Adjustment Explanation	Adjustments
<b>Expenditures adjustments:</b>		
Personnel Services: Administrative salaries	To correct wages incorrectly allocated to administrative salaries, should be chargeable to another program.	\$   (xxx)
Client oriented service salaries	To correct erroneous posting of payroll for pay period ending May 10, 19XX.	   _____ xx
Total personnel service cost adjustments		   _____ xx
<b>Operational expenses:</b>		
Utilities	To adjust for expenses charged to this contract which pertain to another program.	   (xx)
Total operating expense adjustments		   (xx)
Total expenditure adjustments		\$ (xx)

**Section 6250.04 (Cont.)**

**ABC NOT-FOR-PROFIT CORPORATION  
COORDINATING OFFICE FOR DRUG AND ALCOHOL ABUSE PROGRAMS  
CITY OF PHILADELPHIA CONTRACT NUMBER XX-XXXX  
RECONCILIATION OF AGENCY REPORTED EXPENDITURES/REVENUES  
TO AUDITED EXPENDITURES/REVENUES (CONT.)  
July 1, 19XX to June 30, 19XX**

Budget Category	Adjustment Explanation	Adjustments
<b>Funding source adjustments:</b>		
Medical assistance fees	To record previously denied billings which were collected by agency and not reported.	\$ xxx
	To adjust reserve for uncollectible billings on current year billings.	(x)
Total medical assistant fees adjustments		\$ xxx

**Section 6250.05**

**ABC NOT-FOR-PROFIT CORPORATION**  
**COORDINATING OFFICE FOR DRUG AND ALCOHOL ABUSE PROGRAMS**  
**CITY OF PHILADELPHIA CONTRACT NUMBER XX-XXXX**  
**STATEMENT OF UNITS OF SERVICE AND PROGRAM REVENUE**  
**JULY 1, 19XX to JUNE 30, 19XX**

Type of Service	Total Units of Service Per Audit	Approved Unit Rate	Gross Cost	Less: Program Revenue	Net Billing Per Audit
Residential	xxx	\$ xx.xx	\$ xxxxx	\$ (xxx)	\$ xxxx

**Detail of Program Revenue:**

Type of Service	Program Revenues Related To					Total Program Revenue
	Client Fees	Private Health Ins.	Food Stamps	Other Third Party Fees	Other Income	

## **CODAAP - EXHIBITS TABLE OF CONTENTS**

<b>EXHIBIT</b>	<b>DESCRIPTION</b>
1.	Outpatient Instructions
1A.	Service Objectives Projections - Outpatient Form
2.	Inpatient Service Objectives Instructions
2A.	Service Objectives Projections - Inpatient Form
2B	Service Objectives Projections – Step-Down or Recovery Housing
3.	Shelter Service Objectives Instructions
3A.	Shelter Service Objectives
4.	Prevention Instructions
4A.	Prevention Services Objectives Form
5.	Intervention Instructions
5A.	Intervention Service Objectives Form
6.	Non-Hospital Experimental Service Objectives Form
7.	Instructions Year-to-Date Fiscal Report and Cash Request with Sample Forms
8.	Instructions for Fee-for-Services Invoice/Report and Form
8A.	Fee-for Service Invoice/Report
8B.	Guidelines for Billing for Fee-for-Service Residential Days

## Exhibit 1

### 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)**

## Exhibit 1 (Cont.)

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 FY97.

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 EQUIVALENTS: 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 EQUIVALENTS:** 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.

**Exhibit 1A**

**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 CASEMANAGERS \_\_\_\_\_
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)

## Exhibit 2

### 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.
  - 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 in 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.
16. **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 EQUIVALENTS:** 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 EQUIVALENTS:** 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.

**Exhibit 2A**

**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: \_\_\_\_\_  
Assistant Health Commissioner for CODAAP

**Exhibit 2B**

**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)

### **Exhibit 3**

## **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.

**Exhibit 3A**

**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 \_\_\_\_

## Exhibit 4

### 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)**