

New York State

Office of Alcoholism and Substance Abuse Services (OASAS)
Office of Mental Health (OMH)
Office for People with Developmental Disabilities (OPWDD)

***Consolidated
Budget Reporting
And
Claiming Manual***

For the Periods:

*January 1, 2010 to December 31, 2010
July 1, 2010 to June 30, 2011*

Issued: *February 15, 2010*

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Introduction

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

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

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

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

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

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

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

The information contained in this manual documents and explains procedures and step-by-step instructions for fulfilling fiscal reporting requirements related to the receipt of State Aid in the CFRS.

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Contacts

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

For Budgeting:

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

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

Mr. Michael Serge (518) 402-4321
Office for People with Developmental Disabilities
44 Holland Avenue
Albany, New York 12229

For Claiming:

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

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

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

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Resources

Manuals

[Consolidated Budget Reporting and Claiming Manual \(CBR Manual\)](#)

[Consolidated Fiscal Reporting and Claiming Manual \(CFR Manual\)](#) 

Forms

[Consolidated Budget Report \(CBR\)](#)

[Consolidated Quarterly Reports \(CQR-1, CQR-2 and CQR-3\)](#)

[Consolidated Fiscal Report](#) 

[CFR Extension Requests](#) 

New York State CFR Software

[Interagency New York State Software](#)

Phone: 1-800-HELPNYS
(1-800-435-7697)

[Interagency CFRS Training](#)

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

General Instructions

1. In accordance with the instructions contained in this manual, CBRs, CQRs and CCRs must be completed including schedules for each DMH State Agency providing Aid to Localities (State Aid) funding to the service provider. Aid to Localities funding may be provided directly to the service provider through a contract with the funding DMH State Agency(ies) or through a contract with the Local Governmental Unit (LGU) by means of the County Approval Letter process.
2. The same array of programs reported on an approved CBR must also be included on the CQR, CCR and CFR, and for Article 28 Hospitals, the Institutional Cost Report (ICR). If a provider reports a program discretely on an approved CBR, that program must also be reported discretely on all other fiscal documents submitted to the DMH State Agency and the Department of Health. For example, providers may not report a case management program's expenses and revenues as a discrete program on one document, but include those same revenue and expenses as part of a clinic treatment program on a different document. Programs should only be reported discretely if they are operated as individual programs and are not part of a larger program.
3. Service providers receiving funding from more than one County LGU must complete separate CBRs, CQRs and the DMH-2, and DMH-3 schedules in the CCR for each county. Costs will be distributed between each county based on units of service or percentages approved by the funding DMH State Agency(ies).
4. A DMH State Agency's portion of a shared program is reported on the *same* CBR, CQR and CCR schedules with programs funded solely by that DMH State Agency. An example of a shared program is LGU Administration (program code 0890). Additionally, fiscal information for shared programs must be submitted to each State agency associated with the funding of that shared program.
5. Section 41.47(k) of the Mental Hygiene law specifies that any county that receives Community Support Services (CSS) funding and which has a population of less than 100,000 or which has total program expenditures for mentally ill persons equal to or less than \$500,000 in a local fiscal year shall be permitted flexibility in regard to the commingling of funds. Any county that meets at least one of these two criteria, and has OMH programs funded through both CSS and LA, does not have to treat each funding source as a separate program.
6. For LGU operated service providers, the accounting entity is determined by the New York State Office of the State Comptroller according to categories contained in the

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Unified System of Accounts for Counties (USAC).

7. It is the responsibility of LGUs to ensure that local contract funded service providers:
 - i. have the appropriate fiscal record keeping expertise to record and report expenditures and revenues in accordance with the instructions, policies and practices contained in this manual and related resources, and
 - ii. fiscal reporting is accomplished in a consistent and timely manner.

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

OMH-Specific General Instructions

1. All service providers receiving net deficit funding from OMH for any program must include *all* certified and non-certified mental health programs, except for non-funded inpatient programs, on all CBRs, CFRs and CCRs. This requirement includes those programs certified by OMH and funded entirely by Medicaid. OMH will not approve a CBR that does not include all licensed/certified mental health programs.
2. The Office of Mental Health is changing the way it requires providers to report subcontract arrangements beginning with the 07/01/07-06/30/08 reporting period. The requirements are being revised to better reflect the costs of providing the needed services by eliminating double reporting. This will also allow providers to report in a way which will match the inventory of programs as specified in MHPD.

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

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

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

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Provider B (the subcontractor) will not be required to segregate the expenses and revenues related to this subcontract separately for reporting to OMH. Provider B does not need to report the subcontract as an OMH program on their CBR or CFR. Provider B should include the expenses and revenues related to the operation of this program on their CFR on Schedule CFR-2 as 'Other Programs'. Provider A can request cost information from Provider B if they wish, but should not require the data be entered on a CBR or CFR to support this request.

- When preparing a CBR for OMH, providers must refer to the OMH Resources web site for specific information on the [Aid to Localities Spending Plan Guidelines](#)

OPWDD-Specific General Instructions

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

Miscellaneous Instructions And Information

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

Agency Name & Address	The incorporated name, street and city address of the service provider operating the program site(s).
Agency Code	The agency code number is the five (5) digit number listed on the mailing label of the letter notifying you that a new version of the CBR Manual is available for download.
Program Code	See Appendices E-G for each DMH State Agency's valid program codes. Example: 7070 – Treatment/Apartment.
Program/Site Identification Number	PRU Number, Facility-Unit Code, or Operating Certificate Identification Number
Contract Number	The DMH State Agency contract number or the number of the local county contract with the funding LGU.

Note: If the funding LGU does not use contract numbers, enter the first seven

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(7) letters of the county name as a proxy. If the county name is seven (7) letters or less, enter the complete county name.

2. Each set of CBR, CQR and CCR schedules must be returned with the appropriate State Agency(ies) identification information completed.
3. The DMH State Agencies' policies and procedures regarding the reporting of In-Contact versus Out-of-Contract programs can be found in Appendix Z of this manual and the Consolidated Fiscal Reporting and Claiming Manual (CFR Manual). A definition of In-Contract/Out-of Contract can also be found in the Glossary (Appendix A) of this manual and the CFR Manual.

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

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

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

- *Accrual Accounting*

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

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

- *Modified Accrual Accounting*

Modified accrual accounting treats revenues and expenditures as follows:

Revenues are recorded when received except:

- ◆ Those revenues which are susceptible to accrual. Revenues are susceptible to accrual if they are measurable and available to finance the operations of the current year. "Available" means collectible within the current accounting period or soon enough thereafter to be used to pay liabilities of the current period. Generally, such time "thereafter" should not exceed 60 days.
- ◆ Those revenues of a material amount that have not been received at the normal time of receipt. Revenues of a material amount ordinarily recorded on a cash basis will be accrued if receipt is delayed beyond the normal time of receipt.

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

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

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- *Cash Accounting*

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

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

General Instructions

1. Consolidated Budget Reports (CBR), Consolidated Quarterly Reports (CQR) and Consolidated Claiming Reports (CCR) may be completed using one of the three recognized methods of accounting described above.
2. Service providers and LGUs must use the same method of accounting for all CBR, CQR and CCR submissions within the same fiscal reporting period. Service providers and LGUs must also use the same method of accounting for all CBR, CQR and CCR submissions from year to year.
3. Service providers cannot change their method of accounting without *prior* approval by the funding DMH State Agency(ies) and, if funded through a local contract, the funding LGU.
4. LGUs cannot change their method of accounting without *prior* approval by the funding DMH State Agency(ies).

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All of the Consolidated Fiscal Report (CFR) state agencies expect that all Consolidated Budget Report (CBR), Consolidated Quarterly Report (CQR) and CFRs will be completed using approved New York State (NYS) CFRS software. CFR Interagency Committee approved software is available only from the New York State Office of Mental Health. CFRs generated by software not approved by the CFR Interagency Committee will not be accepted.

The approved NYS CFRS software application has been reviewed by the CFR Interagency Committee and contains the functionality to:

1. Calculate and allocate agency administration expenses using the prescribed ratio value methodology,
2. Calculate FTEs to three (3) decimal places,
3. Calculate sub-totals and page totals,
4. Carry forward totals from certain schedules to specific lines on other schedules
5. Create an upload file for electronic submission of CFR documents via the Internet and,
6. Create and print in the specified formats.

Approved NYS CFRS software will also:

- Perform the edits required by the CFR Interagency Committee.
- Assign a unique Document Control Number (DCN) to the CFR submission each time the final validations are run successfully.
 - A DCN indicates that final calculations and carry forwards have been completed.
 - A CFR **must** have a DCN before it can be uploaded.
 - The assigned DCN will appear on each page of a printed CFR and will become part of the upload file for that submission.

NYS CFRS software is updated, approved and released for each calendar and July/June reporting period. Each version of NYS CFRS software can be used for the current reporting period and for all reporting periods, both calendar and July/June, going back to 2002/2003. If an agency needs to revise any prior period CFR dating back to 2002/2003, they should download

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the most recently released version of the NYS CFRS software from the OMH CFRS website and then import and revise the prior period CFR accordingly.

CFRs generated by approved NYS CFRS software **must** be submitted electronically via the Internet. Assignment of a DCN is required before the submission upload file can be created. The state agencies do not currently accept electronic signatures for the certification schedules (CFR-i, CFR-ii or CFR-iiA, and CFR-iii). Therefore, signed paper copies of the certification schedules must be sent to each applicable state agency along with a copy of the service provider's certified financial statements, if applicable. The DCN on the certification schedules must match the DCN of the Internet submission.

To obtain information concerning [approved NYS CFRS software](#), contact the appropriate New York State Agency(ies) listed in Section 8.0. A listing of the approval status of NYS CFRS software is also available.

The Office of Mental Health maintains a [webpage related to the NYS CFRS software](#).

The CFRS homepage includes links to pages for:

- Downloading the software
- Instructions for installing the software
- Instructions for importing your previous submissions
- Uploading the submissions
- Obtaining manual and forms
- Information on enrolling in web based training sessions
- Various resources to help the users find answers to their questions

The software also has help available on many topics from the menu. You should be able to complete most tasks using the information found in HELP.

If you have questions regarding the operation of the CFRS software, and are unable to find the answers in the software's HELP or at the above referenced web site, please phone 1-800-HELP-NYS (1-800-435-7697) for assistance (if you are located outside of New York State, please call 1-518-474-5554).

Web based training opportunities are available for the CFRS software. Please note that this is software training, not accounting and reporting training. This software training is done over the Internet at your own computer. You will be given a link to a website to log into and a telephone

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number for a conference call. This training will be scheduled every Tuesday and Thursday mornings at 10:00 A.M. and will last approximately 1 to 1.5 hours. To sign up call the Help Desk number (1-800-HELP-NYS) and tell them you would like to sign up for CFRS software training and you will be contacted to schedule a session.

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Each Department of Mental Hygiene (DMH) State Agency has different policies, procedures and practices regarding budget modifications.

Office of Alcoholism and Substance Abuse Services (OASAS) Budget Modifications

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

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

Office of Mental Health (OMH) Budget Modifications

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

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

Office for People With Developmental Disabilities (OPWDD) Budget Modifications

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

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

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Process

Submission Dates

Receipt of current year final budgets
Office for People With Developmental Disabilities
(OPWDD)

<i>Counties</i>	<i>New York City</i>
February 15	December 31

Receipt of county operated and service provider budgets
for the current fiscal year Office of Alcoholism and
substance Abuse Services (OASAS)

October 1 (with work scope)	March 1 (with work scope)
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Receipt of County Preliminary Allocation Summary Office
of Mental Health (OMH)

April 1	October 1
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Receipt of final budgets (OMH)

November 1	October 1
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Note: *OASAS funded service providers should address any questions they may have regarding submission of budget related materials to their OASAS Field Office Program Specialist.*

For OMH funded service providers, failure to report by specified due dates may result in the withholding of state aid payments.

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

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

Fiscal Record Keeping Requirements

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

1. Service providers are required to account for expenditures and revenues by program category as budgeted and approved by the funding DMH State Agency(ies).
2. Journals and ledgers must comply with generally accepted accounting standards and should be maintained as prescribed by the funding DMH State Agency(ies).
3. Service providers must maintain all documentation supporting the fiscal data reported in accordance with generally accepted accounting standards.
4. DMH State Agency standards and requirements are the minimum standards and requirements required of funded service providers. LGUs may establish additional documentation and/or submission requirements consistent with LGU practices.
5. Service providers must maintain records and supporting documentation for a period of six (6) years after the date of the last State Aid payment made by the funding DMH State Agency(ies). These records and supporting documentation must be made available at all times, without prior notice, for audit and evaluation by representatives of the funding DMH State Agency(ies) and/or the Office of the State Comptroller (OSC) and/or the Federal Government.
6. Service providers will require subcontract agencies to make available to the DMH State Agency, OSC and/or the Federal Government during regular business hours all financial data related to the services provided under the contract.

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General Fiscal Reporting Requirements

1. County operated service providers *must* allocate agency administration expenses to the DMH State Agencies using the ratio value methodology. After allocating each funding DMH State Agency its ratio value share of agency administration, county operated service providers must allocate each DMH State Agency's share between that State Agency's programs using the same methodology utilized in the approved operating budget for the fiscal reporting period.
2. County operated and not-for-profit service providers *must* indicate the method of accounting used on the appropriate intra-year and final State Aid claim documents. Service providers cannot change their method of accounting without specific prior approval from the funding DMH State Agency(ies) and, if funded through a local contract, the LGU.
3. At a minimum, county operated and not-for-profit service providers are required to submit fiscal reports to the LGU or, in the case of direct contracts, to the funding DMH State Agency in accordance with established time frames. At their discretion, LGUs may implement more frequent reporting requirements consistent with existing LGU practices in such matters.
4. *Reimbursable* expenditures reported *must* be within the amounts established in the county operated or not-for-profit service provider's approved budget and contract (if applicable). Reimbursable expenditures are also subject to limits established by the funding DMH State Agency(ies).
5. County operated and not-for-profit service providers encountering changes in program operations that significantly alter the original budget must modify that budget to better reflect the fiscal activity of the service provider under the changed conditions. (For County operated and not-for-profit service providers funded by OASAS, prior approval of changes in program operations or approved budgets is required.) These budgetary changes should be submitted no later than April 30 (August 15 for New York City) of the following fiscal year. This is particularly critical for LGU administration budgets and in shared programs where shifts in actual service delivery may affect the distribution of funding among/between DMH State Agencies. Please see Section 5 for more information on the modification of service provider approved budgets.
6. Allowable costs under all State Aid funding arrangements with DMH State Agencies *must* meet *all* of the following criteria:
 - i. necessary and reasonable for proper and effective program operations;
 - ii. specifically provided for in the approved budget;
 - iii. not prohibited by Federal, State or Local laws, regulations and/or policies;

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- iv. not allocable or included as a cost of any other program in a prior, current, or subsequent fiscal period; and
- v. not specifically prohibited in Appendix X of this manual and the Consolidated Fiscal Reporting and Claiming Manual (CFR Manual).

Intra-Year Fiscal Reporting Requirements (OASAS and OPWDD Only)

Note: *OMH and OPWDD do not require the submission of intra-year claims.*

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

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

1. County operated and not-for-profit service providers will use the Agency Quarterly Fiscal Summary (CQR-1.1, CQR-1.2, CFR-i, and CFR-iii.) to report intra-year fiscal activity as follows:

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

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

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

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quarterly, monthly, etc.).

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

2. County operated and not-for-profit service providers will prepare CQR-1s in accordance with the instructions provided in this manual.
3. County operated and not-for-profit Article 28 hospitals that are approved by the funding DMH State Agency(ies) to use the "Medicaid Option" will report actual intra-year expenditures and revenues consistent with the "Medicaid Option" procedures described in Appendix Y of this manual and the CFR Manual.
4. County operated and not-for-profit service providers will prepare CQR-1s within the time frames established by the funding DMH State Agency(ies) and/or LGU for receipt by the funding DMH State Agency as follows:
 - OASAS: Direct Contracts: The mid-year claim for direct contracts is due for receipt by OASAS no more than 45 days after the end of the first six months of the fiscal reporting period.
 - LGUs: The mid-year claim for LGUs is due for receipt by OASAS no more than 45 days after the end of the first six months of the fiscal reporting period.
 - OMH: OMH funded service providers are not required to submit intra-year claims.
 - OPWDD: OPWDD funded service providers are not required to submit intra-year claims.
5. County operated and not-for-profit service providers will prepare revised CQR-1s for expenditures and revenues incurred during the fiscal reporting period that were not included on the original CQR-1 submitted for that period or to correct errors on the original CQR-1 submitted. Revised CQR-1s should be completed consistent with the service provider's approved method of accounting and reporting.
6. Cumulative fiscal data should take into account any adjustments made to the county operated or not-for-profit service provider's CQR-1 as a result of LGU and/or OASAS review and approval.
7. County operated service providers *must* allocate agency administration expenses to programs other than LGU administration (program code 0890). LGU administration is considered a unique cost center separate and distinct from agency administration

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expenses incurred by other county operated programs. Agency administration expenses for the management and oversight of all county operated programs other than program code 0890 *cannot* be included in the expenses reported under program code 0890. Please see Appendix I and Appendix K of this manual and the CFR Manual for more detailed information on agency administration and LGU administration.

8. County operated and not-for-profit service providers *must* report and distribute agency administration expenses using the same methodology utilized in their approved budget.
9. County operated and not-for-profit service providers with programs serving more than one LGU and/or DMH State Agency *must* take the total expenditures for the program(s) and distribute them between the affected LGUs' and/or State Agency's(ies') CQR-1s based on the relative units of service provided for each LGU and/or DMH State Agency.

The approved methodology for distributing these expenditures is as follows:

Methodology

- a. First, determine the following information from the aggregate statistical information for the fiscal reporting period:
 - i. The cumulative total units of service for *all* funding DMH State Agencies.
 - ii. The total OASAS-specific units of service.
 - iii. The total OMH CSS units of service.
 - iv. The total OMH Local Assistance units of service.
 - v. The total OPWDD Chapter 620 units of service.
 - vi. The total OPWDD non-Chapter 620 units of service.
- b. Second, determine the cumulative total program expenditures for the fiscal reporting period for all funding DMH State Agencies.
- c. Third, divide the total cumulative expenditures by total cumulative units of service to develop the program's gross cost per unit of service.

Note: *Use six (6) decimal places in applying the gross cost per unit of services for the calculations below.*

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- d. Fourth, determine the gross expenditures attributable to each funding DMH State Agency's funding source(s) by multiplying the units of service for each funding source by the gross cost per unit of service developed in item 6 c above.
10. *For OPWDD funded programs only:* Service providers must account for and report revenue and net expenditures in accordance with the revenue allocation methodologies used in their approved budgets. There are two (2) accepted revenue allocation methodologies:
- "Participant Specific Revenue Allocation Methodology" allocates the amount of revenue attributable to each funding source in a program based on the revenue generated by the participants specific to the program. After entry of the revenue data on the CQR-1 by program and funding source, net expenditures are determined by subtracting applied revenues from total expenses.
 - "Non-Participant Specific Revenue Allocation Methodology", allocates revenues and net expenditures to each funding source in a program based on the net cost per unit of service developed using the same methodology illustrated in Item 7 above.

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

Note: Use six (6) decimal places in applying the net cost per unit of services for the calculations below.

11. Total LGU administration expenditures (program code 0890) *must* be allocated to OASAS CQR-1s using the approved 1988 percentages found in Appendix K of this manual and the CFR Manual.
12. County operated and not-for-profit service providers *must* submit their intra-year claims as follows in accordance with the timeframes indicated in Item 4 of this section:
- Service providers receiving State Aid through a local county contract with an LGU will submit their CQR-1's to the contracting LGU.
 - Service providers receiving State Aid through both a local county contract with an LGU and a direct contract with OASAS will submit CQR-1s to both the contracting LGU *and* the funding DMH State Agency simultaneously.
 - Service providers receiving State Aid solely through a direct contract with OASAS will submit CQR-1s directly to the funding DMH State Agency.

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

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

Final Fiscal Reporting Requirements

1. County operated and not-for-profit service providers will use the State Aid claiming schedules included in the year-end Consolidated Fiscal Report (CFR) as the final claim. These schedules are referred to as the Consolidated Claim Report (CCR) and consist of the CFR-i, CFR-iii, DMH-2.1, and DMH-2.2 State Aid Claiming schedules included in the complete CFR document.
2. County operated and not-for-profit service providers will prepare CCRs in accordance with the instructions provided in the Consolidated Fiscal Reporting and Claiming Manual (CFR Manual).
3. County operated and not-for-profit service providers *must* prepare CCRs using the same methodologies and principles used to prepare their approved budgets and intra-year State Aid claims.
4. County operated and not-for-profit hospital providers that are approved by the funding DMH State Agency(ies) to use the "Medicaid Option" will report actual year-end expenditures and revenues on the CCR consistent with the "Medicaid Option" procedures described in Appendix Y of this manual and the CFR Manual.
5. County operated and not-for-profit service providers will prepare CCRs within the time frames established by the funding DMH State Agency(ies) and/or LGU for receipt by the funding DMH State Agency(ies) as follows:

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

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

LGUs: The CCR for LGUs is due for receipt by OASAS

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no more than 120 days after the end of the fiscal reporting period.

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

LGUs: Service providers funded through a local contract with an LGU should refer to the LGU's fiscal reporting requirements and the OMH Aid to Localities Spending Plan Guidelines.

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

LGUs: Service providers funded through a local contract with an LGU should refer to the LGU's fiscal reporting requirements

6. County operated service providers *must* allocate agency administration expenses to programs other than LGU administration (program code 0890). LGU administration is considered a unique cost center separate and distinct from agency administration expenses incurred by other county operated programs. Agency administration expenses for the management and oversight of all county operated programs other than program code 0890 *cannot* be included in the expenses reported under program code 0890. Please see Appendix I and Appendix K of this manual and the CFR Manual for more detailed information on agency administration and LGU administration.
7. County operated and not-for-profit service providers *must* report and distribute agency administration expenses on the CCR using the same methodology utilized in their approved budget.
8. County operated and not-for-profit service providers with programs serving more than one (1) DMH State Agency must account for these expenditures as follows:

CFR Cost Report (Core) Schedules: On CFR core schedules CFR-1, CFR-4, CFR-4A and DMH-1, programs are reported as sites on individual DMH State Agency schedules or on shared program schedules.

CCR Final Claim Schedules: On CCR final claim schedules DMH-2, and DMH-3, programs are reported on

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DMH State Agency specific, county specific schedules.

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

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

CFR Cost Report (Core) Schedules: On CFR core schedules CFR-1, CFR-4, CFR-4A and DMH-1 programs serving and/or operating in more than one (1) county are reported as sites on individual DMH State Agency schedules or shared program schedules.

CCR Final Claim Schedules: On CCR final claim schedules DMH-2, and DMH-3 individual programs serving and/or operating in more than one (1) county are reported on DMH State Agency specific, county specific schedules.

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

10. *For OPWDD funded programs only:* Service providers *must* account for and report revenue and net expenditures on the CCR in accordance with the revenue allocation methodologies described in item 9 of Service Provider Intra-Year Fiscal Reporting Requirements.
11. Total LGU administration expenditures (program code 0890) *must* be allocated to each funding DMH State Agency's CCR using the approved 1988 percentages found in Appendix K of this manual and the CFR Manual. Agency administration expenses for county operated programs cannot be included in program code 0890 (see item 6 above).

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12. Service providers must submit their CCR final claims as follows in accordance with the timeframes indicated in Item 5 of this section:
- a. Service providers receiving State Aid solely through a local county contract with an LGU will submit their CCRs to the contracting LGU.
 - b. Service providers receiving State Aid through both a local county contract with an LGU and a direct contract with a DMH State Agency will submit CCRs to both the contracting LGU *and* the funding DMH State Agency simultaneously.
 - c. Service providers receiving State Aid solely through a direct contract with a DMH State Agency will submit CCRs directly to that DMH State Agency.
 - d. A service provider that provides services for more than one LGU must submit separate CCRs for each LGU.

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

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

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

- i. Maintenance of LGU fiscal records,
- ii. LGU oversight of county operated and local contract funded not-for-profit service provider fiscal record maintenance.
- iii. preparation and submission of LGU fiscal reports, and
- iv. LGU oversight of county operated and local contract funded not-for-profit service provider fiscal report preparation and submission.

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

Fiscal Record Keeping Requirements

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

1. It is the LGU's responsibility to ensure that all county operated and local contract funded not-for-profit service providers maintain journals and ledgers in compliance with generally accepted accounting standards.
2. It is the LGU's responsibility to ensure that all county operated and local contract funded not-for-profit service providers' accounting systems are adequate for meeting accountability and reporting requirements.
3. It is the LGU's responsibility to ensure that county operated and local contract funded not-for-profit service providers account for expenditures and revenues by program category as budgeted for and approved by the funding DMH State Agency(ies).
4. It is the LGU's responsibility to ensure that fully executed local contracts exist between the LGU and all non-county operated not-for-profit service providers.
5. It is the LGU's responsibility to ensure that fully executed local contracts contain all mandatory State and, if applicable, Federal clauses.

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

OASAS: OASAS does not require copies of local contracts.

OMH: OMH does not require copies of local contracts.

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

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

LGU General Fiscal Reporting Requirements

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

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

OMH and OPWDD Note: *OMH and OPWDD do not require the submission of mid-year claims.*

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

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2. It is the LGU's responsibility to submit the required claim schedules for all local funded service providers to the applicable DMH State Agency(ies) by the prescribed submission due dates.
3. It is the LGU's responsibility to ensure that expenditures and revenues are reported properly and in accordance with specific funding DMH State Agency requirements.
4. It is the LGU's responsibility to ensure that the expenses reported are necessary and reasonable for proper and effective program operation.
5. It is the LGU's responsibility to ensure that the expenses and revenues reported are consistent with and in compliance with each funded service provider's approved budget.
6. It is the LGU's responsibility to ensure that correct program categories, program codes and program code indexes are used.
7. It is the LGU's responsibility to ensure that correct funding codes and funding code indexes are used (See the service provider's approved budget and/or the LGU State Aid Approval Letter).
8. It is the LGU's responsibility to ensure the mathematical accuracy and proper distribution of costs for shared programs. Shared programs are program categories funded by more than one DMH State Agency (OASAS, OMH and/or OPWDD).
9. It is the LGU's responsibility to ensure the proper application of the weighted units of service methodology where appropriate.
10. It is the LGU's responsibility to ensure that total LGU administration expenditures (program code 0890) are allocated to each DMH State Agency in accordance with the DMH approved 1988 percentages found in Appendix K of this manual and the CFR Manual.
11. It is the LGU's responsibility to ensure that agency administration expenses are reported on all county operated and local contract funded not-for-profit service providers claim schedules and are allocated in accordance with the service provider's approved budget.

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

12. It is the LGU's responsibility to ensure that any expenses reported that are prohibited by Federal, State or Local laws, regulations and/or policies are adjusted out prior to the reimbursement of State Aid. Please refer to Appendix X of this manual and the CFR

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Manual for a list of some, but not all, unallowable expenses.

13. It is the LGU's responsibility to ensure that reported expenses are not allocable to or included as an expense of any other program in a prior, current or subsequent fiscal reporting period.
14. It is the LGU's responsibility to ensure that revenues are credited to the appropriate program categories and are reported in accordance with the revenue allocation methodology in each service provider's approved budget.

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

15. For programs with measurable units of service, it is the LGU's responsibility to review county operated and local contract funded not-for-profit service providers' mid-year claims to ensure that each program is on track to deliver the total units of service committed to in the service providers approved budget (CBR). Furthermore, it is the LGU's responsibility to follow up with those service providers demonstrating serious deviations from their budgeted service delivery commitment to determine the need for technical assistance, budget modification and/or other corrective measures.
16. LGUs will ensure that Article 28 hospital providers approved to use the "Medicaid Option" by the funding DMH State Agency(ies) have reported expenditures and revenues consistent with the "Medicaid Option" procedures described in Appendix Y of this manual and the CFR Manual.
17. It is the LGU's responsibility to identify service provider expenditure overruns, revenue shortfalls, and significant service delivery performance variances. If warranted, it is the responsibility of the LGU to ensure that the affected service providers:
 - receive needed technical assistance and/or
 - prepare a budget modification in accordance with specific DMH State Agency and LGU requirements and/or
 - take the appropriate corrective measures to rectify fiscal and/or programmatic deficiencies.
18. It is the LGU's responsibility to ensure that service providers use the same method of accounting to budget for and report expenditures and revenues. Service providers *cannot* change their method of accounting without expressed written approval by the funding DMH State Agency(ies) *prior* to implementation.

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

LGU Mid-Year Fiscal Reporting Requirements

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

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

1. The LGU will receive mid-year Agency Quarterly Fiscal Summaries (CQR-1.1, CQR-1.2, CFR-i, and CFR-iii) from all county operated and local contract funded not-for-profit service providers receiving State Aid through the LGU. These mid-year CQR-1s will report expenses, revenues, net operating costs and funding code information for the first six (6) months of the fiscal reporting period.

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

2. It is the LGU's responsibility to ensure that county operated and local contract funded not-for-profit service providers have completed their CQR-1s in accordance with the instructions contained in this manual.
3. It is the LGU's responsibility to review county operated and local contract funded not-for-profit service providers' mid-year claims to ensure that the fiscal information reported is in compliance with the service provider's approved budget.
4. After receipt and review of all county operated and local contract funded not-for-profit service provider's mid-year claiming schedules, the LGU will prepare an LGU Quarterly Funding Summary (CQR-3) in accordance with the instructions provided in this manual. *Service providers and/or programs funded by a direct contract with a funding DMH State Agency are not included on the mid-year CQR-3.*
5. LGUs will prepare a Mid-year claim package for each funding DMH State Agency consisting of:

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

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LGU Final Fiscal Reporting Requirements

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

1. LGUs will receive final year-end State Aid claiming schedules from all county operated and local contract funded not-for-profit service providers. The final year-end claiming schedules are included as part of the year-end Consolidated Fiscal Report (CFR) and are referred to as the Consolidated Claim Report (CCR). CCRs consist of CFR schedules CFR-i, CFR-iii, DMH-2.1, and DMH-2.2.
2. It is the LGU's responsibility to ensure service providers have completed their CCRs in accordance with the instructions provided in the Consolidated Fiscal Reporting and Claiming Manual.
3. It is the LGU's responsibility to ensure that service providers have prepared their CCRs using the same methodologies and principles used in their approved budgets and mid-year claims.
4. LGUs will prepare a final claim package for each funding DMH State Agency consisting of:

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

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

OPWDD:

- i. Paper copies of CCRs for each county operated and local contract funded service provider funded through a local contract.
- ii. A paper copy of an LGU Fiscal Summary (CQR-3) reporting funding code information for all county operated and local contract funded not-for-profit service providers.
- iii. A State Aid Voucher (AC-1171) with an original signature completed in

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accordance with Section 21 of this manual.

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

5. LGUs will submit the completed final year-end claim package(s) for receipt by the funding DMH State Agency(ies) as follows:
 - OASAS:* LGU final claim packages are due for receipt by OASAS no later than 120 days after the end of the fiscal reporting period.
 - OMH:* LGU final claim packages are due for receipt by OMH no later than 135 days after the end of the fiscal reporting period. (165 days if 30 day CFR Extensions have been submitted.)
 - OPWDD:* LGU final claim packages are due for receipt by OPWDD no later than 135 days after the end of the fiscal reporting period. (165 days if 30 day CFR Extensions have been submitted.)

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	For the Periods: January 1, 2010 to December 31, 2010 July 1, 2010 to June 30, 2011	Issued: February 15, 2010

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

1. to Local Governmental Units (LGUs) for pass through to county operated and local contract funded not-for-profit service providers, and
2. to county operated and not-for-profit service providers funded through a direct contract with one or more of the Department of Mental Hygiene (DMH) State Agencies.

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

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

Advance Payments - Local Governmental Units (LGU's) – All DMH State Agencies

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

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

Office of Alcoholism and Substance Abuse Services

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

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

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

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

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two (2) months of the quarter payable within the first 10 days of each month.

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

Office of Mental Health

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

Office for People With Developmental Disabilities

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

2. OASAS and *OPWDD* advance payments for the April - June quarter and the quarters that follow are subject to:
 - i. the timely passage of New York State Budget appropriations for the fiscal reporting period,
 - ii. approval of budget certificates by the NYS Division of the Budget, and
 - iii. segregation of the appropriated funds by the Office of the State Comptroller.

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

3. Generally, 100% of an LGU's approved State Aid allocation will be advanced for a fiscal reporting period. However, at the discretion of the funding DMH State Agency, total advance payments provided may be limited to ninety percent (90%) of an LGU's approved State Aid allocation.
4. At the discretion of the funding DMH State Agency, advance payments may be adjusted to reflect the actual fiscal reporting experience of county operated and local contract funded service providers.

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5. At the discretion of the funding DMH State Agency, LGU advance payment amounts may be reduced as a result of delinquent county operated and local contract funded service provider budgets, contracts or claim submissions, delinquent submission of signed State Aid funding Authorizations (OASAS only), Disproportionate Share (DSH) Memorandums of Understanding (OASAS only) and/or serious under spending. Generally, these reductions will not be applied to those service providers that have established cyclical spending patterns.
6. LGUs must forward advance payments to all local contract funded service providers *within 30 days of the advance's receipt by the LGU*. Advances should be made in accordance with the contractual advance payment schedule. LGUs shall have discretionary authority to withhold advances from service providers not in compliance with reporting requirements.
7. DMH State Agency processing of LGU advances for payment by the Office of the State Comptroller is also predicated on the following requirements:

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

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

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

8. Each individual DMH State Agency will carefully monitor performance in meeting the above requirements. Requirements not met in a specific quarter will be carried over to succeeding quarters. Non-compliance with these requirements may result in advances being reduced or not processed at all.
9. If the LGU or individual service provider comes into compliance within 30 days after the beginning of the quarter, an individual DMH State agency may process an "off-cycle" advance payment; otherwise, the individual DMH State Agency may postpone payment until the next scheduled advance payment date.

Advance Payments - OASAS Direct Contractors

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

1. The policy of OASAS is to provide advance payments to direct contract-funded service providers based on the following criteria:
 - i. A contract between OASAS and the direct contract-funded service provider has been approved and fully executed by the State Attorney General and the Office of the State Comptroller; and
 - ii. OASAS may provide advance payments from State funds and/or Federal funds as follows:

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

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

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

New York State Consolidated Budget and Claiming Manual	Subject: Advance Payments	Section/Page: 9.5
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Contractor will then receive two (2) one (1) month advance payments for the remaining two (2) months of the quarter payable within the first 10 days of each month.

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

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

2. A final payment, if needed, will be made to the direct contractor based on the fiscal data reported on the DMH-2.1, DMH-2.2 and CFRi State Aid claiming schedules of the Consolidated Fiscal Report.
3. An optional fifth quarter payment *may be provided at OASAS' discretion*, based on the following criteria:
 - i. Service provider receipt of a Written Directive signed by OASAS.
 - ii. Must be allowed for in the current service provider direct contract agreement.
4. Prior period overpayments and/or audit recoveries can be recouped against any payment OASAS makes to a direct contract-funded service provider. The recoupment generally begins with the first payment made to the direct contract-funded service provider following OASAS identification of the of the overpayment and/or audit recovery amount.

Advance Payments - OMH Direct Contractors

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

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

1. The contract has been approved by the State Attorney General and the Office of the State Comptroller.
2. Requirements stated in the contract/guidelines have been met, such as the submission of an expenditure report or a program report.
3. The optional payment or fifth quarter payment is based on the following:

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- i. A Written Directive signed by the Director of Community Budget Service.
 - ii. Must be allowed for in the current contract.
4. Advances are made in accordance with the payment schedule in each contract. Advances may be withheld or reduced if any of the conditions specified in the contract or guidelines have not been met.

Advance Payments - OPWDD Direct Contractors

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

1. The contract has been approved by the State Attorney General and the Office of the State Comptroller.
2. Direct contract agencies shall submit to OPWDD a State Aid Voucher (AC-1171) requesting an advance representing the approved limit established in the approved contract.
3. The combined amount of the first and second quarter advance shall be limited to fifty percent (50%) of the annualized State Aid contract amount.
4. The State Aid Voucher submitted for the third quarter advance shall be limited to twenty-five percent (25%) of the State Aid contract amount.
5. The State Aid Voucher submitted for the fourth quarter advance shall be limited to 15% of the State Aid contract amount, which reflects a 10% hold back of the total contract amount..
6. A final payment, if needed, will be made to the direct contractor based on the fiscal data indicated in the Consolidated Fiscal Report.

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

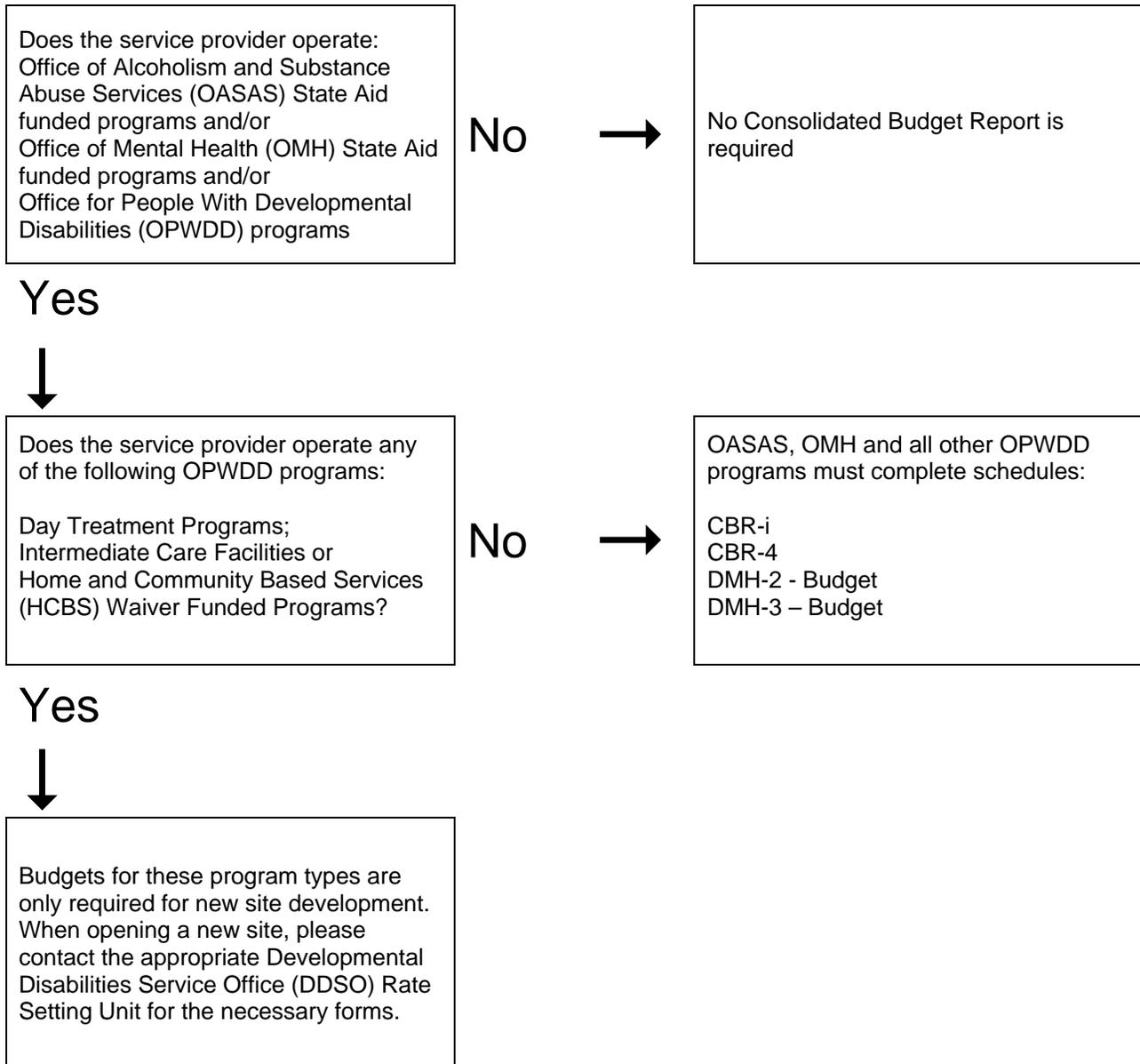
7. The optional advance payment is based on the following:
 - i. Payment of the optional advance payment must be approved by the local DDSO.
 - ii. The receipt of a voucher (AC-1171) by the Bureau of Community Funding. Prior year overpayments and audit recoveries can be recovered against any payment being paid to a voluntary local service provider. Usually recovery will begin against the next available payment.

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

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*New York State
Consolidated Budget Report
Document Submission Matrix*



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

New York State Consolidated Budget and Claiming Manual	Subject: CBR-i – Agency Identification and Certification Statement	Section/Page: 11.1
	For the Periods: January 1, 2010 to December 31, 2010 July 1, 2010 to June 30, 2011	Issued: February 15, 2010

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

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

For The Period

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

Agency Name

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

Agency Address

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

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

Agency Code

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

County Name

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

County Code

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

Office of Mental Health

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

Type of Ownership

Enter the organization's type of ownership:

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

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

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

Person to Contact

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

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

State Agency(ies)

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

Date Prepared

Enter date this document was completed.

Number of Pages

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

New York State Consolidated Budget and Claiming Manual	Subject: CBR-4 Personal Services	Section/Page: 12.1
	For the Periods: January 1, 2010 to December 31, 2010 July 1, 2010 to June 30, 2011	Issued: February 15, 2010

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

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

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

- i. One (1) set reports program specific personal service expenses, and
- ii. One (1) set reports agency administration personal service expenses.

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

Program Specific CBR-4 General Instructions

1. A separate CBR-4 schedule is completed for each funding DMH State Agency.
2. A separate Department of Mental Health (DMH) State Agency specific CBR-4 is completed for each Local Governmental Unit (LGU) funding a program or programs operated by the service provider.
3. Program specific CBR-4s can only include program/site, program administration and/or LGU administration position title codes (100–599 and 700–799).

Agency Administration Specific CBR-4 General Instructions

1. Article 28 hospitals are not required to complete an agency administration CBR-4.
2. Only one (1) agency administration CBR-4 is completed.
3. The agency administration CBR-4 schedule includes the *total* service provider agency administration personal services expenses *not* just those expenses associated with the funding DMH State Agency(ies) and/or LGU(s).
4. Agency administration CBR-4 schedules can only include agency administration position title codes (600-699).
5. All funding DMH State Agencies and/or LGUs must receive a copy of the same agency administration CBR-4 schedule. There cannot be separate CBR-4 schedules with

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different agency administration personal service expenses sent to each funding DMH State Agency and/or LGU.

General CBR-4 Instructions

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

1. Amounts paid *must* be reported in whole dollars.
2. Include anticipated overtime, bonuses and cafeteria plan or split dollar benefits.
3. FTEs are calculated to three (3) decimal places.
4. Employee hours worked, amounts paid and FTEs must be allocated if any of the following circumstances occur:
 - i. The employee works at more than one (1) program.
 - ii. The employee works in programs funded by more than one (1) DMH State Agency and/or LGU.
 - iii. The employee works in more than one position title (job function).

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

Heading Instructions

For the Period *

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

State Agency *

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

Agency Name *

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

Agency Code *

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

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

Staffing Category

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

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

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

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

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

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

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

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

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

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

New York State Consolidated Budget and Claiming Manual	Subject: CBR-4 Personal Services	Section/Page: 12.4
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OMH funding for this reporting period. If programs have been added or removed from OMH funding, consult with the OMH Field Office for the appropriate array of program codes and indexes to be used.

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

County Code

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

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

Position Title Code

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

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

- i. Select the position title code(s) for the position title description that most closely describes the employee's(s') job function.
- ii. Certain position title codes are only valid for specific DMH State Agencies and/or specific types of programs
- iii. Multiple employees with the same position title code and the same standard work week must be combined and reported on the same line. Position title codes can only be used more than once if employees in the same position title code work different standard work weeks.
- iv. Employees performing job duties relating to more than one position title must be reported using all applicable Position Title Codes based on the hours worked in each different job function.

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Position Title

The appropriate position title(s) for the Position Title Code(s) used selected above.

Standard Work Week

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

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

Hours Paid

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

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

Full Time Equivalent (FTE)

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

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

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

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

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

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

Amount Paid

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

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

Total FTE

For each program reported, the total FTEs is displayed.

Total Amount Paid

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

New York State Consolidated Budget and Claiming Manual	Subject: DMH-2 (Budget) – Aid to Localities/Direct Contract Summary	Section/Page: 13.1
	For the Periods: January 1, 2010 to December 31, 2010 July 1, 2010 to June 30, 2011	Issued: February 15, 2010

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

The following guidelines should be followed in completing this schedule:

1. A separate DMH-2 (Budget) schedule *must* be prepared for each DMH State Agency from which the service provider receives Aid to Localities (State Aid) funding. Aid to Localities funding may be provided directly through a contract with a DMH State Agency or indirectly through a contract with the Local Governmental Unit (LGU).
2. A separate DMH-2 (Budget) schedule *must* be prepared for each county in which the service provider operates programs and receives Aid to Localities (State Aid) funding. Aid to Localities funding may be provided directly through a contract with a DMH State Agency or indirectly through a contract with the Local Governmental Unit (LGU).
3. The programs reported on the DMH-2 (Budget) schedule *must* be arrayed in the same order as they appear on schedules CBR-4, and DMH-3.
4. Total service provider agency administration expenses *must* be allocated among the funding DMH State Agencies using the ratio value methodology. Each funding DMH State Agency's share of agency administration is allocated among that DMH State Agency's funded and/or certified programs as follows:

Office of Alcoholism and Substance Abuse Services

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

Office of Mental Health

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

Office for People With Developmental Disabilities

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

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

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

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

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

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

Heading Instructions

For The Period *

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

State Agency *

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

Agency Name *

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

Agency Code *

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

Date Prepared *

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

County Name and Code *

Enter the name and associated code of the county where the budgeted services will be provided and/or funded through a local contract or, a direct contract with a DMH State Agency. Please see Appendix C of this manual and the Consolidated Fiscal Reporting and

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Claiming Manual (CFR Manual) for a list of New York State counties and their associated county codes.

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

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

Prepared by *

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

Telephone *

Enter the preparer's telephone number.

Column Number

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

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

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

Line Instructions

1. Accounting Method

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

2. Direct (State) Contract Number/(LGU) Local Contract Number

Using the radio button for contract type,

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

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Direct (State) Contract Number: For contracts directly dealing with a DMH State Agency for funding, enter the State Contract Number. i.e. C001234.

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

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

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

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

3. Program Type

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

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4. Program Code & Program Code Index

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

OASAS:

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

OMH:

- i. Use the same array of program codes and indexes as were used during the prior reporting period unless programs have been added or removed from OMH funding for this reporting period. If programs have been added or removed from OMH funding, consult with the OMH Field Office for the appropriate array of program codes and indexes to be used.
- ii. For OMH Community Residences, each supervised site, each MI/MR site and each Children and Youth site is considered a program and must be reported in a separate column.
- iii. For OMH start up program and PDG program codes and indexes, see Appendix F of this manual and the CFR Manual.

OPWDD:

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

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Expenses

5. Personal Services

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

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

6. Vacation Leave Accruals

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

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

7. Fringe Benefits

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

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

8. Other Than Personal Services (OTPS)

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

9. Equipment Provider Paid

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

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

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

10. Property-Provider Paid

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

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

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

11. Agency Administration

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

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

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

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Step 1:

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

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

- LGU Administration (0890),

Program Development Grants (OPWDD),

Step 2:

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

For OMH: Allocate the total OMH share of agency administration to each OMH program using the existing OMH approved allocation methodology.

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

- LGU Administration – OMH Reinvestment and MGP (0860).
- Monitoring and Evaluation, CSS (0870),
- FEMA Crisis Counseling Assistance and Training (1690)
- Non-Medicaid Care Coordination Service Dollars (2820)
- Conference of Mental Hygiene Directors (2860)
- Case Management Administration (2810)
- Blended Case Management Service Dollars (0920)
- Start-up programs with an "A" as the program code index.
- RTF Coordinator and HCBS Service Dollar (2980)
- Assertive Community Treatment (ACT) Team – Service Dollars (8810)
- Intensive Case Management Service (1910)
- Adult Home Service Dollars (6920)
- Supportive Case Management Service Dollars (6910)
- Flexible Recipient Service Dollars (1230)

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

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

12. Adjustments/Non-Allowable Costs

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

13. Total Adjusted Expenses

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

Revenues

14. Participant Fees (less SSI & SSA)

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

15. SSI & SSA

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

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16. Home Relief

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

17. Medicaid Regular

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

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

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

OMH Note: *Include the anticipated Community Support Program (CSP) Medicaid revenue expected during the local fiscal year. For budgeting and claiming purposes, include the CSP revenue in the column of the appropriate CSP program; for not the licensed outpatient program (clinic, CDT, or day treatment program) generating the CSP revenue. See Appendix DD of this manual and the CFR Manual for more information on COPS and CSP Medicaid revenue.*

18. Medicare

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

19. Other Third Parties

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

20. OPWDD Residential Room and Board/NYS OPTS

Make no entry. Not applicable for OPWDD CBRs.

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21. Transportation, Medicaid

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

22. Transportation, Other

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

23. Sales: Contract Total

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

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

24. Federal Grants (Attach detail)

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

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

25. State Grants (Attach detail)

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

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

- i. The revenues *must* be received *directly* from a non CFR NYS Agency; and
- ii. The revenues *must* be a component of the program funded by the applicable DMH State Agency.

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

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26. LTSE Income Total (OMH and OPWDD Only)

OASAS: Make no entry.

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

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

27. Food Stamps (OASAS Only)

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

OMH: Make no entry.

OPWDD: Make no entry.

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

For CBRs only, make no entry on this line.

29. Other Revenue

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

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

- i. Disproportionate Share (DSH)
- ii. Closely Allied Entities
- iii. Voluntary Contributions
- iv. TANF
- v. Prior Year Revenue.

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

- i. Non-Medicaid CRs Prior Years
- ii. ICM Prior Years
- iii. SCM Prior Years
- iv. BCM Prior Years
- v. ACT Prior Years
- vi. Accrued Disproportionate Share (DSH) Revenue
- vii. Federal Salary Sharing (See Appendix V of this Manual and the CFR Manual for more information about OMH Federal Salary Sharing.)
- viii. CSP Reserve Prior Years (See Appendix DD of this Manual and the CFR Manual for more information about CSP.)
- ix. Level I COPS Prior Years
- x. Level II Non-COPS Prior Years.
- xi. Adult Home Supportive Case Management prior years

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

30. Total Gross Revenues

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

GAAP Adjustments To Revenue

31. Participant Allowance

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

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32. Uncollectible Accounts Receivable

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

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

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

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

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

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

34. Total GAAP Adjustments

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

35. Net GAAP Revenues

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

Non-GAAP Adjustments To Revenue

36. Exempt Contract Income

For each applicable program, enter the anticipated exempt contract income for the reporting period. Exempt contract income is calculated by subtracting participant wages and raw materials from total contract sales. Worksheets supporting the calculation of exempt contract income *must* be maintained by the service provider.

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

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

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37. Exempt LTSE Income

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

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

38. Net Deficit Funding

For CBRs only, make no entry on this line.

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

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

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

- i. Not Applied Revenue

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

- i. OMH Share Medicaid CR
- ii. Provider Share Medicaid
- iii. CSP Reserve
- iv. Level I COPS Reserve
- v. ICM Current Year Exempt
- vi. SCM Current Year Exempt
- vii. BCM Current Year Exempt
- viii. ACT Current Year Exempt

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ix. Level II COPS Reserve

x. Adult Home Supportive Case Management current year exempt

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

40. Total Non-GAAP Adjustments

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

41. Subtotal Adj. to Revenue

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

42. Total Net Revenues

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

43. Net Operating Cost

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

Deficit Funding

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

44. State

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

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

45. Local Government

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

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

46. Service Provider Share (Voluntary Contributions)

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

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

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

47. Total Approved Deficit Funding

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

48. Non-Funded

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

49. Total Net Deficit

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

Note: Line 49 must equal line 43.

Percent (%) Of Net Costs

The amounts entered on line 44 of the DMH-2 are calculated by applying the percentages applicable for each funding source code used on the DMH-3 and then totaling all the results.

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Funding Source code information can be found in Appendix N of this manual and the CFR Manual.

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

Unified Services Rates

<i>County</i>	<i>Disability</i>	<i>Percentage</i>
Rensselaer	OASAS, OMH and OPWDD	86.85%
Rockland	OASAS, OMH and OPWDD	69.50%
Warren	OASAS, OMH and OPWDD	87.10%
Washington	OASAS, OMH and OPWDD	96.99%
Westchester	OASAS, OMH and OPWDD	69.32%

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

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Reserved For Future Use

New York State Consolidated Budget and Claiming Manual	Subject: DMH-3 (Budget) – Aid to Localities and Direct contracts Program Funding Source summary	Section/Page: 15.1
	For the Periods: January 1, 2010 to December 31, 2010 July 1, 2010 to June 30, 2011	Issued: February 15, 2010

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

The following guidelines should be followed in completing this schedule:

1. A separate DMH-3 (Budget) schedule must be prepared for each DMH State Agency from which the service provider receives Aid to Localities (State Aid) funding. Aid to Localities funding may be provided directly through a contract with a DMH State Agency or indirectly through a contract with the Local Governmental Unit (LGU).
2. A separate DMH-3 (Budget) schedule must be prepared for each county in which the service provider operates programs and receives Aid to Localities (State Aid) funding. Aid to Localities funding may be provided directly through a contract with a DMH State Agency or indirectly through a contract with the Local Governmental Unit (LGU).
3. The programs reported on the DMH-3 (Budget) schedule *must* be arrayed in the same order they appear on the CBR-4, and DMH-2 (Budget).

Heading Instructions

For the Period *

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

State Agency *

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

Agency Name *

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

Agency Code *

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

Date Prepared *

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

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

County Name and Code *

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

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

Prepared by *

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

Telephone *

Enter the preparer's telephone number.

Column Number

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

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

Line Instructions

1. Accounting Method

For each reported program, enter the method of accounting used i.e., accrual, modified accrual or cash. Use the same method of accounts as DMH-2. Please refer to Section 3.0 of the manual for more information on accounting methods.

2. Program Type

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

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

3. Program Code & Program Code Index

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

OASAS:

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

OMH:

- i. Use the same array of program codes and indexes as were used during the prior reporting period unless programs have been added or removed from OMH funding for this reporting period. If programs have been added or removed from OMH funding, consult with the OMH Field Office for the appropriate array of program codes and indexes to be used.
- ii. For OMH Community Residences, each supervised site, each Mental Illness/Mental Retardation (MI/MR) site and each Children and Youth site is considered a program and must be reported in a separate column.
- iii. For OMH start up program and PDG program codes and indexes, see Appendix F of this manual and the CFR Manual.

OPWDD:

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

4. Total Persons Served/Month

For each reported program, enter the anticipated average number of persons to be

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served on a monthly basis.

5. **Total Units of Services**

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

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

6. **Gross Cost/Unit of Service**

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

7. **Net Cost/Unit of Service**

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

8. **Please check:**

OASAS: Make no entry.

OMH: Make no entry.

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

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

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

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

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

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

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

Funding Source Code/Index

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

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

- OASAS:** For each reported program, enter the applicable alphabetic funding source index in the box to the right of the three digit numeric funding source code on lines 9, 16 and/or 23. The funding source code(s) and indexes used should be consistent with the service provider's most recently approved budget as indicated on the county LGU Funding Authorization (Approval Letter) or Appendix B of OASAS direct contracts. Valid OASAS funding source code indexes are F, M, O, S, C or P. OASAS Funding source code indexes are defined in Appendix N of this manual and the CFR Manual.

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

OPWDD: Make no entry.

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

Non-Funded Expenses

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

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

Line Instructions

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

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

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

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

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

Total Adjusted Expenses (line 12, 19, and 26)

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

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

For each unique funding source code and index in a program, enter the applicable

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allocated portion of Total Net Revenues from the DMH-2 (Budget) schedule.

Net Operating Costs (line 14, 21, and 28)

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

Contract Number (line 15, 22, and 29)

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

Direct (State) Contract Number For contracts directly dealing with a funding DMH State Agency, to enter the State Contract Number, i.e. C001234, TM08012.

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

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

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

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

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Block D - Totals from A-C Above:

30. Total Adjusted Expenses

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

31. Less Net Revenue

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

32. Net Operating Costs

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

Total Column

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

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

Provision of State Aid

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

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

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

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

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

Differences Between Cost Reporting And State Aid Claiming

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

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State Aid claiming is accomplished using intra-year claim schedules (CQR-1.1 and CQR-1.2, CFR-I and CFR-iii) (OPWDD & OASAS) and the CFR-i, CFR-iii, DMH-2.1 and DMH-2.2 claiming schedules of the Consolidated Claim Report (CCR) that is included as part of a complete CFR submission. State Aid claiming schedules may be completed using accrual, modified accrual or cash accounting and major equipment assets may be completely expensed in the year of purchase. Additionally, the total agency administration expenses allocated to OASAS and OMH using the ratio value methodology may be redistributed between programs within the OASAS and OMH schedules using an allocation methodology other than ratio value (OPWDD funded service providers must use ratio value on their claiming schedules as well as on their CFR core schedules).

OMH Only Providers:

Please refer to Appendices I and T for instructions on calculating ratio value allocations of agency administration.

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

Programs Funded By More Than One (1) DMH State Agency And/Or LGU

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

OMH maintains a master provider directory (CONCERTS) which contains information on the providers and programs licensed, certified by or funded by the OMH. It is necessary that each provider and county maintain the list of their programs registered with OMH through the Mental Health Provider Data exchange (MHPD) system.

County PASs and provider CBRs will be compared to the CONCERTS file when submitted. If the budgeted programs are not found in CONCERTS, the submission will fail. The county or provider will need to correct their submission or update their records through MHPD in order to pass the edits.

More information on the [MHPD process](#) can be found online.

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

Expenses, revenues and net operating costs should be allocated between LGUs and/or DMH State Agencies using units of service or New York State approved percentages, whichever is appropriate. Service providers should verify the allocation methodology to be used with the funding DMH State Agency(ies) and or LGU(s).

LGU Administration Expenses (Program Code 0890)

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

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

Note: *LGUs cannot allocate indirect costs following the guidelines issued by the Federal Office of Management and Budget (OMB) in their circular A-87. New York State policy regarding OMB Circular 74-4 can be found in Section 35.9 of this manual. .*

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

General State Aid Claiming Requirements

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

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

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

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

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

OASAS LGU General Instructions

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

Intra-year claims are completed on the Agency Quarterly Fiscal Summary (CQR-1.1, CQR-1.2, CFR-i, and CFR-iii). Final claims consist of the Consolidated Claim Report (CCR). The OASAS CCR is comprised of the CFR-i, CFR-iii, DMH-2.1, and DMH-2.2 of the year-end Consolidated Fiscal Report (CFR).

Instructions for completing CQR-1s are included in this manual. Instructions for completing and submitting CFRs and CCRs are described in the Consolidated Fiscal Reporting and Claiming (CFR) Manual. LGUs should ensure that all county operated and not-for-profit service providers complete and submit their CFRs and associated CFR-i, CFR-iii, DMH-2.1, and DMH-2.2 claim schedules in accordance with the instructions provided in the CFR Manual issued for the correct fiscal reporting period.

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

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

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

- To correct erroneous intra-year or final claim schedules submitted to OASAS.

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

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

OASAS LGU Submission Requirements

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

NYS Office of Alcoholism and Substance Abuse Services
Bureau of Financial Management
4th Floor
1450 Western Avenue
Albany, NY 12203-3526

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

OASAS LGU Due Dates

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

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

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

OASAS LGU Intra-Year Claims

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

Counties

- CQR-1.1 and CQR-1.2 - for each county operated and not-for-profit service provider receiving State Aid through the LGU
- CFR-i and CFR-iii

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NYC DOHMH

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

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

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

OASAS LGU Final Claims

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

Counties

- DMH2.1 and DMH2.2 - for each county operated and not-for-profit service provider receiving State Aid through the LGU
- CFR-i and CFR-iii

NYC DOHMH

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

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

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

In the event that one or more county operated or not-for-profit service provider's CFR has not been completed or finalized in time for the LGU to meet the submission due date, the LGU should not delay in submitting the claim to OASAS. Instead, preliminary ("estimated") CCRs (CFR-i, CFR-iii, DMH-2.1 and DMH-2.2) should be submitted for the delinquent service providers.

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

1. receives copies of the delinquent service provider’s(s’) final claim schedules derived from their completed and finalized CFR(s); and,
2. submits a revised final claim package to OASAS that includes the replacement DMH-2.1, DMH-2.2, CFR-i, and CFR-iii incorporating any changes necessitated by those new final claim schedules.

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

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

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

OASAS Direct Contract Service Provider General Instructions

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

The standard intra-year State Aid claim is the mid-year claim covering the first six (6) months of the fiscal reporting period. However, at its discretion, OASAS may require direct contract service providers to submit three (3) quarterly State Aid claim packages. Intra-year claims consist of CQR-1.1, CQR-1.2 and CFR-i.

The final State Aid claim package covers the complete 12 month fiscal reporting period. Final claims consist of the Consolidated Claim Report (CCR). The CCR is comprised of the CFR-i, DMH-2.1, and DMH-2.2 of the year-end Consolidated Fiscal Report (CFR).

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

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

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

- To correct erroneous intra-year claim (CQR-1.1 and CQR-1.2) schedules that were previously submitted to OASAS.
- To correct erroneous final claim (DMH-2.1, and DMH-2.2 claim schedules that were previously submitted to OASAS.

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

OASAS Direct Contract Service Provider Submission Requirements

In addition to the electronic submission, OASAS currently, requires that direct contract service providers submit paper copies of mid-year, quarterly (if required) and final State Aid claim packages to the following address:

NYS Office of Alcoholism and Substance Abuse Services
Bureau of Financial Management
4th Floor
1450 Western Avenue
Albany, NY 12203-3526

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

OASAS Direct Contract Service Provider Due Dates

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

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

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

New York State Consolidated Budget and Claiming Manual	Subject: OASAS Requirements for the Preparation and Submission of State Aid Claims	Section/Page: 17.6
	For the Periods: January 1, 2010 to December 31, 2010 July 1, 2010 to June 30, 2011	Issued: February 15, 2010

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

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

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

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

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

Quarterly Claims (if required)

- CQR-1.1 and CQR-1.2
- CFR-i

Mid-Year Claims

- CQR-1.1 and CQR1.2
- CFR-i

OASAS Direct Contract Service Provider Final Claims

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

- DMH-2.1 and DMH2.2
- CFR-i

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

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

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

New York State Consolidated Budget and Claiming Manual	Subject: OMH Requirements for the Preparation and Submission of State Aid Claims	Section/Page: 18.1
	For the Periods: January 1, 2010 to December 31, 2010 July 1, 2010 to June 30, 2011	Issued: February 15, 2010

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

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

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

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

OMH LGU General Instructions

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

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

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

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

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

New York State Consolidated Budget and Claiming Manual	Subject: OMH Requirements for the Preparation and Submission of State Aid Claims	Section/Page: 18.2
	For the Periods: January 1, 2010 to December 31, 2010 July 1, 2010 to June 30, 2011	Issued: February 15, 2010

OMH LGU Submission Requirements

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

OMH LGU Due Dates

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

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

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

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

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

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

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

OMH Direct Contract Service Provider General Instructions

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

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

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

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	For the Periods: January 1, 2010 to December 31, 2010 July 1, 2010 to June 30, 2011	Issued: February 15, 2010

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

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

OMH Direct Contract Service Provider Due Dates

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

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

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

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

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

New York State Consolidated Budget and Claiming Manual	Subject: OPWDD Requirements for the Preparation and Submission of State Aid Claims	Section/Page: 19.1
	For the Periods: January 1, 2010 to December 31, 2010 July 1, 2010 to June 30, 2011	Issued: February 15, 2010

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

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

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

OPWDD LGU General Instructions

For each fiscal reporting period, LGUs are required to submit one (1) State Aid claim packages to OPWDD. The final claim package covers the complete 12 month fiscal reporting period.

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

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

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

- To correct erroneous final claim schedules that have already been submitted to OPWDD.

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

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

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

New York State Consolidated Budget and Claiming Manual	Subject: OPWDD Requirements for the Preparation and Submission of State Aid Claims	Section/Page: 19.2
	For the Periods: January 1, 2010 to December 31, 2010 July 1, 2010 to June 30, 2011	Issued: February 15, 2010

OPWDD LGU Submission Requirements

OPWDD currently requires that LGUs submit paper copies of final State Aid claim packages to the following address:

*Claims Management Unit
NYS Office for People with Developmental Disabilities
44 Holland Avenue – 3rd Floor
Albany, NY 12229*

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

OPWDD and LGU Due Dates

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

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

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

OPWDD LGU Final Claims

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

Non-NYC LGUs

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

NYC DOHMH

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

New York State Consolidated Budget and Claiming Manual	Subject: OPWDD Requirements for the Preparation and Submission of State Aid Claims	Section/Page: 19.3
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CCRs for both non-NYC LGUs and the NYC DOHMH consist of the CFR-i, CFR-iii, DMH-2 and DMH-3 schedules of the year-end CFR.

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

OPWDD Direct Contract Service Provider General Instructions

For each fiscal reporting period, OPWDD direct contract funded service providers are required to submit final State Aid claim packages.

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

Instructions for completing and submitting CFRs and CCRs are described in the Consolidated Fiscal Reporting and Claiming (CFR) Manual.

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

- “Revised” *final* State Aid claims should be submitted to correct erroneous DMH-2 and/or DMH-3 claim schedules that were previously submitted to OPWDD.

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

OPWDD Direct Contract Service Provider Due Dates

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

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

OPWDD Direct Contract Service Provider Quarterly Vouchers

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

New York State Consolidated Budget and Claiming Manual	Subject: OPWDD Requirements for the Preparation and Submission of State Aid Claims	Section/Page: 19.4
	For the Periods: January 1, 2010 to December 31, 2010 July 1, 2010 to June 30, 2011	Issued: February 15, 2010

OPWDD Direct Contract Service Provider Final Claims

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

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

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

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

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

New York State Consolidated Budget and Claiming Manual	Subject: DMH Processing of State Aid Fiscal Reports	Section/Page: 20.1
	For the Periods: January 1, 2010 to December 31, 2010 July 1, 2010 to June 30, 2011	Issued: February 15, 2010

This section of the manual describes the general overall processing of State Aid claim submissions by the Department of Mental Hygiene (DMH) State Agencies.

Establishing Control Records

The first step in the DMH State Agencies processing of any State Aid claim is the establishment of control records. Office of Alcoholism and Substance Abuse Services (OASAS), Office of Mental Health (OMH) and Office for People with Developmental Disabilities (OPWDD) establish specific control records consistent with the level of control each State Agency requires.

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

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

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

State Aid Claims Received By the DMH State Agencies

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

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

Screening of State Aid Claims

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

New York State Consolidated Budget and Claiming Manual	Subject: DMH Processing of State Aid Fiscal Reports	Section/Page: 20.2
	For the Periods: January 1, 2010 to December 31, 2010 July 1, 2010 to June 30, 2011	Issued: February 15, 2010

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

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

Review of State Aid Claims

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

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

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

New York State Consolidated Budget and Claiming Manual	Subject: DMH Processing of State Aid Fiscal Reports	Section/Page: 20.3
	For the Periods: January 1, 2010 to December 31, 2010 July 1, 2010 to June 30, 2011	Issued: February 15, 2010

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

OMH will apply the rules as contained in the Spending Plan Guidelines for each funding source. These rules can be found on the [OMH web](#).

Reconciliation of State Aid Claims to Advances

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

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

New York State Consolidated Budget and Claiming Manual	Subject: AC-1171 State Aid Voucher	Section/Page: 21.1
	For the Periods: January 1, 2010 to December 31, 2010 July 1, 2010 to June 30, 2011	Issued: February 15, 2010

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

The (NYS) Office of Mental Health (OMH) and the NYS Office of Alcoholism and Substance Abuse (OASAS) do not require the submission of State Aid Vouchers for advance payments or State Aid claim payments.

General Instructions

1. State Aid Vouchers contain the following information relevant to the payee:
 - Identification of the funding State Agency (OPWDD),
 - the name and address of the payee,
 - the payee identification number,
 - reference information that will be printed on the check stub to identify the payment to the payee,
 - identification of the period the advance payment or State Aid claim covers, and
 - payee certification that the advance payment requested or State Aid claim is in accordance with all applicable laws or regulations
2. State Aid Vouchers may be completed using the multi-part form issued by the Office of the State Comptroller or a computer generated facsimile.
3. Manually completed vouchers *must* be prepared using blue or black ink or typewritten.
4. Computer generated State Aid Voucher facsimiles *must* be identical reproductions of the multi-part form.
5. All State Aid Vouchers submitted *must* be legible.
6. All advance payments requested, expenditures and revenues reported and/or State Aid claimed *must* be rounded to the nearest whole dollar.

New York State Consolidated Budget and Claiming Manual	Subject: AC-1171 State Aid Voucher	Section/Page: 21.2
	For the Periods: January 1, 2010 to December 31, 2010 July 1, 2010 to June 30, 2011	Issued: February 15, 2010

Exception: *OPWDD rate-based State Aid programs must use exact calculations.*

7. In this section of the manual “municipality” refers to counties, cities, towns, villages, boroughs and/or any other district incorporated for local self government. Also, for the purposes of this manual, the term “municipality” will also include public schools and school districts.
8. OPWDD reserve the right to reject and return any State Aid Vouchers that do not comply with the policies and procedures described in these instructions.

LGU Instructions

LGUs are required to complete and submit State Aid Vouchers to OPWDD as part of their and final year-end State Aid claim packages.

Voucher Number

Make no entry.

Originating Agency (Box 1)

Enter the acronym for OPWDD as follows:

OPWDD

Orig. Agency Code

Enter the five (5) digit agency code for the State Agency indicated in box 1 as follows:

OPWDD: 51000

Interest Eligible (Y/N)

Make no entry.

Payment Date (MM) (DD) (YY)

Make no entry.

OSC Use Only

New York State Consolidated Budget and Claiming Manual	Subject: AC-1171 State Aid Voucher	Section/Page: 21.3
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Make no entry.

Liability Date (MM) (DD) (YY)

Make no entry.

Payee ID (Box 2) & Additional

Enter the 12 digit Municipality Code assigned to the LGU by the Office of the State Comptroller. Enter the first nine (9) digits of the code in the Payee ID box and the remaining three (3) digits in the Additional box.

Zip Code (Box 3)

Enter the zip code of the city, town or village where the office of the county fiscal officer is located.

Route

Make no entry.

Payee Name, Address, City, State & Zip Code (Box 4)

Enter the *title* of the county fiscal officer and the street address, city, state and zip code for the county fiscal officer. *Do not* enter the name of the county fiscal officer.

Payee Amount

Make no entry.

MIR Date (MM) (DD) (YY)

Make no entry.

IRS Code

Make no entry.

IRS Amount

Make no entry.

Stat. Type

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Make no entry.

Statistic

Make no entry.

Indicator-Dept.

Make no entry.

Indicator-Statewide

Make no entry.

Ref./Inv. No. (MM) (DD) (YY)

Enter information that will identify the payment generated by the voucher. Up to 20 characters (alphabetic and/or numeric) may be used in any combination.

The information entered in this box will be printed on the check stub of any payment generated by this voucher.

Ref./Inv. Date (MM) (DD) (YY)

Make no entry.

Date Paid (Box 6)

Make no entry.

Check or Voucher No. (Box 6)

Make no entry.

Description of Charges (Box 6)

Enter the period covered by the State Aid claim as follows:

Expenses for the period January 1, 200X through June 30, 200X

or

Expenses for the period 01/01/0X – 06-30-0X

New York State Consolidated Budget and Claiming Manual	Subject: AC-1171 State Aid Voucher	Section/Page: 21.5
	For the Periods: January 1, 2010 to December 31, 2010 July 1, 2010 to June 30, 2011	Issued: February 15, 2010

Note: For revised State Aid claims, identify the period covered as described above followed by "Revision # 1". If there are additional revisions follow the same naming convention using the next number (Revision #2, Revision #3, etc.)

Amount (Box 6)

Enter the total expenses reported in column 2, line 25 of the LGU Fiscal Summary (CQR-3) schedule that will be submitted as part of the mid-year or year-end State Aid claim package.

Total

Enter the total expenses reported in column 2, line 25 of the LGU Fiscal Summary (CQR-3) schedule that will be submitted as part of the mid-year or year-end State Aid claim package.

Less Receipts

Enter the total revenues reported in column 2, line 26 of the LGU Fiscal Summary (CQR-3) schedule that will be submitted as part of the mid-year or year-end State Aid claim package.

Net

Enter the total net operating costs reported in column 2, line 27 of the LGU Fiscal Summary (CQR-3) schedule that will be submitted as part of the mid-year or year-end State Aid claim package.

State Aid Claimed

Enter the total State Aid claimed in column 2, line 25 of the LGU Fiscal Summary (CQR-3) schedule that will be submitted as part of the mid-year or year-end State Aid claim package.

State Aid Program or Applicable Statute (Box 7)

Make no entry.

Payee Certification (Box 8)

Signature in Ink: The State Aid Voucher *must* be signed by the county fiscal officer (Treasurer, Controller, etc.) or duly authorized representative. The signature *must* be in blue or black ink.

New York State Consolidated Budget and Claiming Manual	Subject: AC-1171 State Aid Voucher	Section/Page: 21.6
	For the Periods: January 1, 2010 to December 31, 2010 July 1, 2010 to June 30, 2011	Issued: February 15, 2010

Rubber stamp signatures are not allowed.

Date: Enter the date the State Aid Voucher was signed by the LGU Chief Fiscal Officer or duly authorized representative.

Title: Enter the title of the county fiscal officer or duly authorized representative (Treasurer, Controller, etc.).

Name of Municipality: Enter the county name of the LGU.

For State Use Only Section

Make no entry.

State Comptroller's Pre-Audit Section

Make no entry.

Expenditure Section

Make no entry.

Liquidation Section

Make no entry.

Direct Contract Funded Service Provider Instructions

Direct contract funded service providers are required to complete and submit State Aid Vouchers to OPWDD in order to receive advance payments and as part of their mid-year and final year-end State Aid claim packages. The instructions that follow are broken into two (2) sections, one for advance payment voucher completion and one for State Aid claim voucher completion.

Direct Contract Advance Payment Voucher

Voucher Number

Make no entry.

Originating Agency (Box 1)

Enter the acronym for OPWDD as follows:

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OPWDD

Orig. Agency Code

Enter the five (5) digit agency code for the State Agency indicated in box 1 as follows:

OPWDD

Interest Eligible (Y/N)

Make no entry.

Payment Date (MM) (DD) (YY)

Make no entry.

OSC Use Only

Make no entry.

Liability Date (MM) (DD) (YY)

Make no entry.

Payee ID (Box 2) & Additional

Municipalities: Enter the 12 digit Municipality Code assigned to the LGU by the Office of the State Comptroller. Enter the first nine (9) digits of the code in the Payee ID box and the remaining three (3) digits in the Additional box.

Not-for Profits: Enter the service provider's corporate Federal Tax Identification Number. This number *must* match the Federal Tax Identification Number included in the service provider's fully executed direct contract.

Zip Code (Box 3)

Municipalities: Enter the 12 digit Municipality Code assigned to the LGU by the Office of the State Comptroller. Enter the first nine (9) digits of the code in the Payee ID box and the remaining three (3) digits in the Additional box.

New York State Consolidated Budget and Claiming Manual	Subject: AC-1171 State Aid Voucher	Section/Page: 21.8
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Not-for Profits: Make no entry.

Route

Make no entry.

Payee Name, Address, City, State & Zip Code (Box 4)

If a Municipality or Not for Profit has signed up with the Office of the State Comptroller (OSC) for Electronic Funds Transfer (EFT) payments, all information must be consistent with that provided to OSC or payment will not be paid via EFT.

Municipalities: Enter the *title* of the municipal fiscal officer and the street address, city, state and zip code for the municipal fiscal officer. *Do not* enter the name of the municipal fiscal officer.

Not-for Profits: Enter the corporate name, street address, city, state and zip code of the service provider's corporate headquarters.

Payee Amount

Make no entry.

MIR Date (MM) (DD) (YY)

Make no entry.

IRS Code

Make no entry.

IRS Amount

Make no entry.

Stat. Type

Make no entry.

Statistic

Make no entry.

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Indicator-Dept.

Make no entry.

Indicator-Statewide

Make no entry.

Ref./Inv. No. (MM) (DD) (YY)

Enter information that will identify the advance payment generated by the voucher. Up to 20 characters (alphabetic and/or numeric) may be used in any combination.

The information entered in this box will be printed on the check stub of the advance payment generated by the voucher. For example, an OPWDD 1st quarter advance may be given a reference/invoice number of "OPWDD Jan-Feb 04 Adv".

Ref./Inv. Date (MM) (DD) (YY)

Make no entry.

Date Paid (Box 6)

Make no entry.

Check or Voucher No. (Box 6)

Make no entry.

Description of Charges (Box 6)

Enter the contract number and the period covered by the advance payment as follows:

C-000001: Advance payment for the period January 1, 200X through June 30, 200X
or

C-000001: Advance payment for the period 01/01/0X – 06-30-0X

Amount (Box 6)

Enter the amount of the advance payment requested.

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Total

Enter the amount of the advance payment requested.

Note: OPWDD providers should use the advance amount from appendix C of their approved contract.

Less Receipts

Make no entry.

Net

Enter the amount of the advance payment requested.

Note: OPWDD providers should use the advance amount from appendix C of their approved contract.

State Aid Claimed

Enter the amount of the advance payment requested.

Note: OPWDD providers should use the advance amount from appendix C of their approved contract.

State Aid Program or Applicable Statute (Box 7)

Make no entry.

Payee Certification (Box 8)

Municipalities:

Signature in Ink:

The State Aid Voucher *must* be signed by the municipal fiscal officer (Treasurer, Controller, etc.) or duly authorized representative. The signature *must* be in blue or black ink. *Rubber stamp signatures are not allowed.*

Date:

Enter the date the State Aid Voucher was signed by the municipal fiscal officer or duly authorized representative.

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Title: Enter the title of the municipal fiscal officer or duly authorized representative (Treasurer, Controller, etc.).

Name of Municipality: Enter the county name of the LGU.

Not-for-Profits: Signature in Ink: The State Aid Voucher *must* be signed by the chief executive officer or duly authorized representative. The signature *must* be in blue or black ink. *Rubber stamp signatures are not allowed.*

Date: Enter the date the State Aid Voucher was signed by the chief executive officer or duly authorized representative.

Title: Enter the title of the chief executive officer or duly authorized representative (Treasurer, Controller, etc.).

Name of Municipality: Make no entry.

For State Use Only Section

Make no entry.

State Comptroller's Pre-Audit Section

Make no entry.

Expenditure Section

Make no entry.

Liquidation Section

Make no entry.

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	For the Periods: January 1, 2010 to December 31, 2010 July 1, 2010 to June 30, 2011	Issued: February 15, 2010

Direct Contract State Aid Claim Voucher

Voucher Number

Make no entry.

Originating Agency (Box 1)

Enter the acronym for OPWDD as follows:

OPWDD

Orig. Agency Code

Enter the five (5) digit agency code for the State Agency indicated in box 1 as follows:

OPWDD: 51000

Interest Eligible (Y/N)

Make no entry.

Payment Date (MM) (DD) (YY)

Make no entry.

OSC Use Only

Make no entry.

Liability Date (MM) (DD) (YY)

Make no entry.

Payee ID (Box 2) & Additional

Municipalities: Enter the 12 digit Municipality Code assigned to the LGU by the Office of the State Comptroller. Enter the first nine (9) digits of the code in the Payee ID box and the remaining three (3) digits in the Additional box.

Not-for Profits: Enter the service provider's corporate Federal Tax Identification

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Number. This number *must* match the Federal Tax Identification Number included in the service provider's fully executed direct contract.

Zip Code (Box 3)

Municipalities: Enter the 12 digit Municipality Code assigned to the LGU by the Office of the State Comptroller. Enter the first nine (9) digits of the code in the Payee ID box and the remaining three (3) digits in the Additional box.

Not-for Profits: Make no entry.

Route

Make no entry.

Payee Name, Address, City, State & Zip Code (Box 4)

If a Municipality or Not for Profit has signed up with the Office of the State Comptroller (OSC) for Electronic Funds Transfer (EFT) payments, all information must be consistent with that provided to OSC or payment will not be paid via EFT.

Municipalities: Enter the *title* of the municipal fiscal officer and the street address, city, state and zip code for the municipal fiscal officer. *Do not* enter the name of the municipal fiscal officer.

Not-for Profits: Enter the corporate name, street address, city, state and zip code of the service provider's corporate headquarters.

Payee Amount

Make no entry.

MIR Date (MM) (DD) (YY)

Make no entry.

IRS Code

Make no entry.

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IRS Amount

Make no entry.

Stat. Type

Make no entry.

Statistic

Make no entry.

Indicator-Dept.

Make no entry.

Indicator-Statewide

Make no entry.

Ref./Inv. No. (MM) (DD) (YY)

Enter information that will identify the payment generated by the voucher. Up to 20 characters (alphabetic and/or numeric) may be used in any combination.

Ref./Inv. Date (MM) (DD) (YY)

Make no entry.

Date Paid (Box 6)

Make no entry.

Check or Voucher No. (Box 6)

Make no entry.

Description of Charges (Box 6)

Enter the contract number and the period covered by the State Aid claim as follows:

C-000001: Expenses for the period January 1, 200X through June 30, 200X
or C-000001: Expenses for the period 01/01/0X – 06-30-0X

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Note: For revised State Aid claims, identify the period covered as described above followed by "Revision # 1". If there are additional revisions follow the same naming convention using the next number (Revision #2, Revision #3, etc.)

Amount (Box 6)

For The Office For People With Developmental Disabilities:

Final Year-End Claim: Enter the total expenses reported in the Total column, line 30 of the Aid to Localities and Direct Contracts Program Funding Source Summary (DMH-3) schedule that will be submitted as part of the final year-end State Aid claim package.

Total

For The Office For People With Developmental Disabilities:

Final Year-End Claim: Enter the total expenses reported in the Total column, line 30 of the Aid to Localities and Direct Contracts Program Funding Source Summary (DMH-3) schedule that will be submitted as part of the final year-end State Aid claim package.

Less Receipts

For The Office For People With Developmental Disabilities:

Final Year-End Claim: Enter the total revenues reported in the Total column, line 31 of the Aid to Localities and Direct Contracts Program Funding Source Summary (DMH-3) schedule that will be submitted as part of the final year-end State Aid claim package.

Net

For The Office For People With Developmental Disabilities:

Final Year-End Claim: Enter the total net operating costs reported in the Total column, line 32 of the Aid to Localities and Direct Contracts Program Funding Source Summary (DMH-3) schedule that will be submitted as part of the final year-end State Aid claim package.

State Aid Claimed

Enter the total State Aid claimed for the year-end State Aid claim package.

State Aid Program or Applicable Statute (Box 7)

Make no entry.

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Expenditure Section

Make no entry.

Liquidation Section

Make no entry

New York State Consolidated Budget and Claiming Manual	Subject: CQR-1 Agency Quarterly Fiscal Summary	Section/Page: 22.1
	For the Periods: January 1, 2010 to December 31, 2010 July 1, 2010 to June 30, 2011	Issued: February 15, 2010

The Consolidated Quarterly Report (CQR)-1.1, CQR-1.2, Consolidated Fiscal Report (CFR)-i, and CFR-iii for Local Governmental Unit (LGU)'s Agency Quarterly Fiscal Summary schedule is used to report intra-year expenses, revenues, net operating costs and funding sources for programs receiving Aid to Localities (State Aid) funding from the NYS Office of Alcoholism and Substance Abuse Services (OASAS), NYS Office of Mental Health (OMH) and NYS Office for People with Developmental Disabilities (OPWDD).

Note: *The NYS Office of Mental Health (OMH) and the NYS Office for People with Developmental Disabilities (OPWDD) do not require the submission of intra-year claims. Accordingly, OMH and OPWDD do not require the submission of CQR-1 claim schedules.*

General Instructions

The CQR-1.1, CQR-1.2, CFR-i, and CFR-iii for LGU's is only used to report intra-year fiscal information. A final CQR-1 is *not* required and should *not* be submitted. For final claim submissions the consolidated Claim Report (CCR) schedules included as part of the year-end Consolidated Fiscal Report (CFR) are used.

1. Separate OASAS-specific CQR-1.1, CQR-1.2, and CFR-i schedules *must* be prepared.
2. Separate OASAS-specific CQR-1.1, CQR-1.2, CFR-i, and CFR-iii schedules *must* be prepared for each county in which the service provider operates programs and/or from which the service provider receives State Aid funding.
3. Additional CQR-1 continuation schedules are required if:
 - i. a service provider operates more than four (4) programs and/or
 - ii. receives State Aid reimbursement from more than four (4) unique funding code and funding code index combinations.
4. The overall flow of the CQR-1 schedule is as follows:
 - Column 1 displays the service provider's approved budget.
 - Column 2 displays the service provider's cumulative (local fiscal year-to-date) approved expenses, revenues and net operating costs.
 - Column 3 displays the sum of columns 4–7 (or more if required) exclusive of lines 15–19, 23–25, 31–33, 39–41 and 47-49.

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

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Heading Instructions – CQR-1.1 and CQR-1.2

State Agency *

Indicate the reported programs for OASAS services.

Fiscal Period *

Enter the beginning and ending dates of the complete 12 month fiscal reporting period (01/01/XX to 12/31/XX, 07/01/XX to 06/31/XY, etc.). *Do not* enter the dates of the quarter or mid-year period for which expenses and revenues are being reported.

Quarter Reported *

Indicate the specific intra-year claim period the CQR-1 covers (i.e. 1st quarter, 2nd quarter, mid-year, etc.).

Agency Name *

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

Prepared by *

Enter name of person that prepared the CQR-1 and can answer questions about the information contained in the document.

Telephone *

Enter the preparer's telephone number.

Agency Code *

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

County Name and Code *

Enter the name and associated two (2) digit code for the county where the reported programs operated and/or were funded through a local county contract. Please see Appendix C of this manual and the Consolidated Fiscal Reporting and Claiming Manual (CFR Manual) for a list of New York State counties and their associated county codes.

LGU *

Local contract funded service providers: Enter the name of the Local Governmental Unit (LGU) that contracted for the reported

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programs.

Direct contract funded service providers: Make no entry.

* Complete this at the top of each page of the CQR-1.1 & CQR-1.2.

LGU Approval By *

LGUs: Enter the name of the individual representing the LGU) that has reviewed and approved the expenses, revenues, net operating costs and funding code information reported on the CQR-1.

Local contract funded service providers: Make no entry.

Direct contract funded service providers: Make no entry.

Program Type *

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

Program Code & Program Code Index *

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

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

Accounting Method (CQR-1.1 only) *

For each reported program, enter the method of accounting used i.e., accrual, modified accrual or cash.

* Complete this at the top of each page of the CQR-1.1 & CQR-1.2.

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	For the Periods: January 1, 2010 to December 31, 2010 July 1, 2010 to June 30, 2011	Issued: February 15, 2010

Line Instructions – CQR-1.1 - Expenses (Columns 4-7)

1. Personal Services

For each reported program, enter the personal services expenses for the reporting period. Do not include agency administration personal services on this line.

2. Vacation Leave Accruals

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

3. Fringe Benefits

For each reported program, enter the fringe benefits that correspond to the personal services reported on line 1. Include FICA, hospitalization, retirement benefits, group life insurance, etc. Do not include agency administration fringe benefits on this line.

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

4. Other Than Personal Services

For each reported program, enter the OTPS expenses for the reporting period. Include food, repairs and maintenance, utilities, telephones, minor expensed equipment (equipment costing less than \$5,000 per unit and having a useful life of less than two (2) years), supplies, etc. Do not include agency administration OTPS expenses on this line.

5. Equipment – Provider Paid

For each reported program, enter the equipment-related expenses for the reporting period. Include the cost of any vehicle and equipment leases on this line. Do not include agency administration equipment expenses on this line. Also, do not include any equipment expenses reported on line 4, OTPS.

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

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6. *Property – Provider Paid*

For each reported program, enter the property-related expenses for the reporting period. Include property lease costs, building depreciation, property casualty insurance, etc. *Do not include agency administration property expenses on this line.*

OASAS Note: *OASAS does not allow service providers to budget for or claim property depreciation for State Aid reimbursement. Only the actual property-related costs incurred can be claimed.*

7. *Agency Administration*

For each applicable program, enter the allocated agency administration expenses for the reporting period. Total county operated and not-for-profit service provider agency administration expenses must be allocated to OASAS and all other funding sources using the ratio value methodology.

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

8. *Adjustments/Non-Allowable Costs*

For each reported program enter the adjustments to reported expenses and/or non-allowable expenses for the reporting period. *The amount(s) entered on line 8 cannot be a negative number.* Please refer to Appendix X of this manual and the CFR Manual for descriptions of some, but not all, non-allowable expenses.

9. *Total Expenses*

For each reported program, enter the sum of lines 1-7 minus line 8.

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Line Instructions – CQR-1.1 - Revenues (Columns 4-7)

10. Methodology (OPWDD Only)

For OASAS program. Make no entry.

11. Medicaid Revenue

For each reported program, enter the actual Medicaid revenue received for the reporting period. (See notes to line 12 below.)

12. Non-Medicaid Revenue

For each reported program, enter the revenues received from all sources other than Medicaid for the reporting period. This includes DSH revenue and revenue received from Medicaid MCOs.

Disproportionate Share (DSH): OASAS service providers should report any DSH revenue received on line 12, Non-Medicaid Revenue.

Medicaid Managed Care: Revenues received directly from a Medicaid Managed Care Organization (MCO) should be reported on line 12, Non-Medicaid Revenue.

13. Total Revenues

For each reported program, enter the sum of lines 11 and 12.

14. Net Operating Costs

For each reported program, enter the result of line 9 minus line 13.

Line Instructions – CQR-1.1 - Miscellaneous (Columns 4-7)

15. State Contract Number/Local Contract Number

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

State Contract Number: For direct contracts with OASAS, enter the State contract number.

LGU Contract Number: For local contracts with a county, enter the local contract number if one is assigned.

Note: *A State or LGU contract number must be entered. If the funding LGU does not*

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use contract numbers, enter the first seven (7) letters of the county name as a proxy. If the county name is seven (7) letters or less, enter the complete county name.

Note: OASAS would prefer that all County operated and Not for Profit service providers funded through a local contract with a County use the first seven (7) letters of the County name rather than an LGU contract number.

16. Total Persons Served (OMH Only)

For OASAS programs, make no entry.

17. Total Units of Service

For each applicable program reported, enter the units of service provided during the reporting period.

Note: *Reporting units of service may not be applicable for certain types of programs. Please see Appendices E and G of this manual and the CFR Manual to determine if units of service should be reported for a specific type of program.*

18. Gross Cost Per Unit

For each program with reported units of service, enter the gross cost per unit of service for the reporting period. The gross cost per unit of service is calculated by dividing the total program expenses reported on line 9 by the total program units of service reported on line 17. The gross cost per unit of service should be calculated to the nearest hundredth place (XXX.XX).

19. Net Cost Per Unit

For each program with reported units of service, enter the net cost per unit of service for the reporting period. The net cost per unit of service is calculated by dividing the total program net operating costs expenses reported on line 14 by the total program units of service reported on line 17. The net cost per unit of service should be calculated to the nearest hundredth place (XXX.XX).

20. Workshop Contract Sales (Direct)

OASAS: Make no entry.

21. Local Government (OASAS Only)

OASAS: For each reported program, enter the amount of local government contribution (local county tax) that is being applied against the net deficit for the reporting period. *Use this line only if one or more of the funding*

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code and funding code indexes used on the CQR-1.2 reimburses State Aid at 100% of the net expenses reported.

22. Voluntary Contributions

OASAS: Make no entry. Voluntary contributions are budgeted for and reported as Non-Medicaid Revenue on line 12.

Line Instructions – CQR-1.2 – General Funding Source Information

If expenses, revenues and net operating costs need to be distributed between funding codes, there are four ways this can be accomplished:

1. Expenses, revenues and net operating costs can be direct charged.
2. Expenses, revenues and net operating costs can be distributed using units of service. When using this method, the ratio of the units of service applied to a funding code or State Agency *must* be calculated using six decimal place multipliers (i.e. .123456). The sum of all multipliers used *must* equal 1.000000.
3. Expenses, revenues and net operating costs can be distributed using a ratio. When using this method, the ratio *must* be calculated using six decimal place multipliers (i.e. .123456). The sum of all multipliers used *must* equal 1.000000..

Please check with the funding State Agency (OASAS) if you have any questions regarding the allocation methodology to be used.

Line Instructions – CQR-1.2 – Funding Code Information (Columns 4-7)

Lines 23, 31, 39 and 47 – Funding Code

For each reported program, enter the applicable three (3) digit funding code(s) used during the reporting period.

OASAS Note: OASAS funded county operated and not-for-profit service providers *must* also enter the alphabetic funding source index. The funding code and funding code index combinations used *must* be consistent with those used in the service provider's most recently approved budget.

County operated and local contract funded not-for-profit service providers can find the correct funding code and funding code indexes to use on the most recently issued OASAS Approval Letter for the fiscal reporting period.

Direct contract funded county operated and not-for-profit service providers can find the correct funding code and funding code indexes to

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use on the most recent Appendix B of their fully executed contract with OASAS.

Only one (1) unique funding code or funding code/funding code index combination can be used on each line.

Lines 24, 32, 40 and 48 – Number of Persons Served (OMH Only)

For OASAS programs, make no entry.

Lines 25, 33, 41 and 49 – Units of Service

For each applicable program, enter the units of service provided during the reporting period.

Note: *Reporting units of service may not be applicable for certain types of programs. Please see Appendices E and G of this manual and the CFR Manual to determine if units of service should be reported for a specific type of program.*

Lines 26, 34, 42 and 50 – Total Expenses

For each unique funding code and funding code index combination used in a reported program, enter the allocated portion of the expenses entered on CQR-1.1, line 9.

Lines 27, 35, 43 and 51 – Revenue: Medicaid

For each unique funding code and funding code index combination used in a reported program, enter the allocated portion of the expenses entered on CQR-1.1, line 11.

Lines 28, 36, 44 and 52 – Revenue: Other

For each unique funding code and funding code index combination used in a reported program, enter the allocated portion of the expenses entered on CQR-1.1, line 12.

Lines 29, 37, 45 and 53 – Total Revenues

For each unique funding code and funding code index combination used in a reported program, enter the allocated portion of the expenses entered on CQR-1.1, line 13.

Lines 30, 38, 46 and 54 – Net Operating Costs

For each unique funding code and funding code index combination used in a reported program, enter the allocated portion of the expenses entered on CQR-1.1, line 13.

New York State Consolidated Budget and Claiming Manual	Subject: CQR-2 NYC Fiscal Summary	Section/Page: 23.1
	For the Periods: January 1, 2010 to December 31, 2010 July 1, 2010 to June 30, 2011	Issued: February 15, 2010

The Consolidated Quarterly Report (CQR)-2 New York City (NYC) Fiscal Summary schedule is completed by the NYC Department of Health and Mental Hygiene (NYC DOHMH). It summarizes mid-year and year-end fiscal activity for service providers receiving Aid to Localities (State Aid) funding from the NYS Office of Alcoholism and Substance Abuse Services (OASAS) and the NYS Office for People with Developmental Disabilities (OPWDD) through a local contract with the NYC DOHMH. Additionally, the CQR-2 is used to establish accountability for advance payments made to local contract funded service providers by the NYC DOHMH.

Note: *The NYS Office of Mental Health (OMH) does not require the submission of the CQR-2 schedule. The NYS Office for People with Developmental Disabilities (OPWDD) does not require the submission of a mid-year CQR-2 but does require the submission of a final CQR-2. The NYS Office of Alcoholism and Substance Abuse Services does not require the submission of the CQR-2 schedule.*

General Instructions

1. Separate OASAS-specific and/or OPWDD-specific CQR-2 schedules *must* be prepared.
2. The mid-year CQR-2 reports fiscal data for the first six (6) months of the fiscal reporting period. The year end CQR-2 reports fiscal data for the full 12 months of the fiscal reporting period.
3. Additional CQR-2 continuation schedules are required if:
 - i. there are more than five (5) funded service providers and/or
 - ii. more than five (5) unique funding code and funding code index combinations.
4. The overall flow of the CQR-2 schedule is as follows:
 - Column 2 displays the sum of columns 3–7 (or more if required) exclusive of line 30.

Heading Instructions

State Agency *

Indicate whether the reported programs are for either OASAS services or OPWDD services.

Fiscal Period *

Enter the beginning and ending dates of the complete 12 month fiscal reporting period (i.e. 07/01/XX to 06/31/XY).

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Quarter Reported *

Indicate the specific intra-year claim period the CQR-1 covers (i.e. 1st quarter, 2nd quarter, mid-year, etc.).

** Complete this at the top of each page of the CQR-2.*

Prepared by *

Enter name of person that prepared the CQR-2 and can answer questions about the information contained in the document.

Title *

Enter the title of the person that prepared the CQR-2 and can answer questions about the information contained in the document.

Telephone *

Enter the preparer's telephone number.

LGU Approval By *

Enter the name of the individual representing the NYC DOHMH that has reviewed and approved the expenses, revenues, net operating costs and funding code information reported on the CQR-2.

Title *

Enter the title of the person that reviewed and approved the CQR-2.

Date Approved *

Enter the date the LGU reviewed CQR-2 was approved.

Funding Code Information (Columns 3-7) *

For each reported service provider, enter the applicable three (3) digit funding code(s) used during the reporting period.

OASAS Note: Funding codes used for OASAS funded county operated and not-for-profit service providers *must* also include the alphabetic funding source index. The funding code and funding code index combinations used *must* be consistent with those used in the service provider's most recently approved budget.

County operated and local contract funded not-for-profit service providers can find the correct funding code and funding code indexes to use on the most recently issued OASAS Approval Letter for the fiscal reporting period.

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Only one (1) unique funding code or funding code/funding code index combination can be used on each line.

** Complete this at the top of each page of the CQR-2.*

Line Instructions

Lines 1-20 – Agency Identification Information

Lines 1, 5, 9, 13 and 17 – Agency Name

Enter the names of the organizations operating the reported programs.

Lines 2, 6, 10, 14 and 18 – Agency Code

Enter the five (5) digit codes assigned to the organizations operating the reported program(s).

Lines 4, 8, 12, 16 and 20 – NYC Contract Number

Enter the NYC DOHMH contract number associated with the agencies entered on lines 1, 5, 9, 13 and 17.

Columns 3-7 – Lines 1-20 - Service Provider Funding Code Information

Note: There will be more than seven (7) columns if more than five (5) unique funding code and funding code indexes are used. Please see page 23.1, General Instructions, item 3 for information on the use of CQR-2 continuation sheets.

Lines 1, 5, 9, 13 and 17 – Total Expenses

For each service provider reported, enter the total expenses for the reporting period in the appropriate funding code/index columns.

Lines 2, 6, 10, 14 and 18 – Revenues

For each service provider reported, enter the total revenues for the reporting period in the appropriate funding code/index columns.

Lines 3, 7, 11, 15 and 19 – Net Operating Costs

For each service provider reported, enter the total net operating costs for the reporting period in the appropriate funding code/index columns.

Lines 4, 8, 12, 16 and 20 – Advances

For each service provider reported, enter the total advance payments provided for the reporting period in the appropriate funding code/index columns.

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Columns 3-7 – Lines 3-24 – Page Total Information

Note: There will be more than seven (7) columns if more than five (5) unique funding code and funding code indexes are used. Please see page 23.1, General Instructions, item 3 for information on the use of CQR-2 continuation sheets.

21. Total Expenses

Enter the sum of the amounts reported on lines 1, 5, 9, 13 and 17 for each funding code and funding code index combination used.

22. Revenues

Enter the sum of the amounts reported on lines 2, 6, 10, 14 and 18 for each funding code and funding code index combination used.

23. Net Operating Costs

Enter the sum of the amounts reported on lines 3, 7, 11, 15 and 19 for each funding code and funding code index combination used.

24. Advances

Enter the sum of the amounts reported on lines 4, 8, 12, 16 and 18 for each funding code and funding code index combination used.

Columns 3-7 – Lines 25-31 – NYC Total Information (Last page(s) of CQR-2 only)

Note: There will be more than seven (7) columns if more than five (5) unique funding code and funding code indexes are used. Please see page 23.1, General Instructions, item 3 for information on the use of CQR-2 continuation sheets.

25. Total Expenses

On the last set of CQR-2 continuation sheets, enter the sum of the amount(s) reported on line 21 of each CQR-2 for each funding code and funding code index combination used.

26. Revenues

On the last set of CQR-2 continuation sheets, enter the sum of the amount(s) reported on line 22 of each CQR-2 for each funding code and funding code index combination used.

27. Net Operating Costs

On the last set of CQR-2 continuation sheets, enter the sum of the amount(s) reported on line 23 of each CQR-2 for each funding code and funding code index combination used.

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28. Advance Amount

On the last set of CQR-2 continuation sheets, enter the sum of the amount(s) reported on line 24 of each CQR-2 for each funding code and funding code index combination used.

29. Total Net/Advances

On the last set of CQR-2 continuation sheets, enter the sum of the amounts reported on lines 27 and 28 of each CQR-2 for each funding code and funding code index combination used.

30. Reimbursement Rate

On the last set of CQR-2 continuation sheets, enter the applicable reimbursement rate for each funding code and funding code index combination used.

31. State Aid Total

On the last set of CQR-2 continuation sheets enter the State Aid amount calculated by applying the reimbursement rate entered on line 30 to the amount entered on line 29 for each funding code and funding code index combination used.

Column 2 State Agency Total Information - Lines 1-20

Lines 1, 5, 9, 13 and 17 – Total Expenses

For each service provider reported, enter the sum of the expenses reported on these lines in columns 3-7.

Lines 2, 6, 10, 14 and 18 – Revenues

For each service provider reported, enter the sum of the revenues reported on these lines in columns 3-7.

Lines 3, 7, 11, 15 and 19 – Net Operating Costs

For each service provider reported, enter the sum of the net operating costs reported on these lines in columns 3-7.

Lines 4, 8, 12, 16 and 20 – Advances

For each service provider reported, enter the sum of the advances reported on these lines in columns 3-7.

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Column 2 – Page Total Information - Lines 21-24

21. Total Expenses

Enter the sum of the amounts reported on lines 1, 5, 9, 13 and 17 of column 2.

22. Revenues

Enter the sum of the amounts reported on lines 2, 6, 10, 14 and 18 of column.

23. Net Operating Costs

Enter the sum of the amounts reported on lines 3, 7, 11, 15 and 19 of column 2.

24. Advances

Enter the sum of the amounts reported on lines 4, 8, 12, 16 and 18 of column 2.

Column 2 – Nyc Total Information - Lines 25-31 (Last page(s) of CQR-2 only)

25. Total Expenses

On the last set of CQR-2 continuation sheets, enter the sum of the amounts reported on line 21 of each CQR-2 submitted.

26. Revenues

On the last set of CQR-2 continuation sheets, enter the sum of the amounts reported on line 22 of each CQR-2 submitted

27. Net Operating Costs

On the last set of CQR-2 continuation sheets, enter the sum of the amounts reported on line 23 of each CQR-2 submitted.

28. Advance Amount

On the last set of CQR-2 continuation sheets, enter the sum of the amounts reported on line 24 of each CQR-2 submitted.

29. Total Net/Advances

On the last set of CQR-2 continuation sheets, enter the sum of the amounts reported on lines 27 and 28 of each CQR-2 submitted.

30. Reimbursement Rate

Make no entry.

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31. *State Aid Total*

On the last set of CQR-2 continuation sheets, enter the sum of the amounts reported on line 31 of each CQR-2 submitted.

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The Consolidated Quarterly Report (CQR)-3 Local Governmental Unit (LGU) Fiscal Summary schedule is completed by Local Governmental Units (LGUs) located outside of the City of New York. It summarizes mid-year and year-end fiscal activity for service providers receiving Aid to Localities (State Aid) funding from the New York State (NYS) Office of Alcoholism and Substance Abuse Services (OASAS) and the NYS Office for People with Developmental Disabilities (OPWDD) through a local contract with the LGU.

Additionally, the CQR-3 is used to establish the basis for reimbursing small counties 75% of the first \$100,000 in net operating costs incurred under Regular Local Assistance funding (funding code 001). Small counties are defined as counties with populations less than 200,000.

Note: *The NYS Office of Mental Health (OMH) does not require the submission of the CQR-3 schedule. The OMH Aid to Localities Financial System (ALFS) will generate the CQR-3 schedule for each LGU.*

The NYS Office for People with Developmental Disabilities (OPWDD) does not require the submission of a mid-year CQR-3 but does require the submission of a final CQR-3.

The NYS Office of Alcoholism and Substance Abuse Services (OASAS) does not require the submission of the CQR-3 schedule.

General Instructions

1. Separate OASAS-specific and/or OPWDD-specific CQR-3 schedules *must* be prepared.
2. Mid-year and year-end CQR-3 schedules are completed. Mid-year CQR-3s cover the first six (6) months of the fiscal reporting period and year-end CQR-3s cover the full 12 month fiscal reporting period.
3. The source(s) of the fiscal information summarized on the CQR-3 is as follows:
 - Mid-Year Claims: Use the funding code and funding code index information reported on page CQR-1.2 of the Agency Quarterly Fiscal Summaries (CQR-1s) submitted by county operated and local contract funded not-for-profit service providers.
 - Year-end Claims: Use the funding code and funding code index information reported on the Aid to Localities and Direct Contracts Program Funding Source Summaries (DMH-3s) submitted by county operated and local contract funded not-for-profit service providers.

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4. Additional CQR-3 continuation schedules are required if:
 - i. there are more than seven (7) funded service providers and/or
 - ii. more than five (5) unique funding code and funding code index combinations.
5. The overall flow of the CQR-3 schedule is as follows:
 - Column 2 displays the sum of columns 3–7 (or more if required) exclusive of line 28.
6. *Do not* include OASAS and OPWDD direct contract funded programs' fiscal information on the CQR-3 schedule.

Heading Instructions

State Agency *

Indicate whether the reported programs are for either OASAS services or OPWDD services.

Fiscal Period *

Enter the beginning and ending dates of the complete 12 month fiscal reporting period (i.e. 01/01/XX to 12/31/XX).

Quarter Reported *

Indicate the specific claim period the CQR-3 covers (i.e. 1st quarter, 2nd quarter, mid-year or final).

County Name and Code *

Enter the name and associated two (2) digit code for the county where the reported programs operated and/or were funded through a local county contract. Please see Appendix C of this manual and the Consolidated Fiscal Reporting and Claiming Manual (CFR Manual) for a list of New York State counties and their associated county codes.

Prepared by *

Enter name of person that prepared the CQR-3 and can answer questions about the information contained in the document.

Title *

Enter the title of the person that prepared the CQR-3 and can answer questions about the information contained in the document.

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Telephone *

Enter the preparer's telephone number.

LGU Approval By *

Enter the name of the individual representing the LGU that has reviewed and approved the expenses, revenues, net operating costs and funding code information reported on the CQR-3.

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

Title *

Enter the title of the person that reviewed and approved the CQR-3.

Date Approved *

Enter the date the LGU reviewed CQR-3 was approved.

Funding Code Information (Columns 3-7) *

Note: There will be more than seven (7) columns if more than five (5) unique funding code and funding code indexes are used. Please see page 24.1, General Instructions, item 4 for information on the use of CQR-3 continuation sheets.

For each reported service provider, enter the applicable three (3) digit funding code(s) used during the reporting period.

Only one (1) unique funding code or funding code/funding code index combination can be used on each line.

Line Instructions

Lines 1-21 – Agency Identification Information

Lines 1, 4, 7, 10, 16 and 19 – Agency Name

Enter the names of the organizations operating the reported programs.

Lines 1, 4, 7, 10, 16 and 19 – Agency Code

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Enter the five (5) digit codes assigned to the organizations operating the reported program(s).

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

Columns 3-7 – Lines 1-21 - Service Provider Funding Code Information

Note: There will be more than seven (7) columns if more than five (5) unique funding code and funding code indexes are used. Please see page 24.1, General Instructions, item 4 for information on the use of CQR-3 continuation sheets.

Lines 1, 4, 7, 10, 16 and 19 – Total Expenses

For each service provider reported, enter the total expenses for the reporting period in the appropriate funding code/index columns.

Lines 2, 5, 8, 11, 14, 17 and 20 – Revenues

For each service provider reported, enter the total revenues for the reporting period in the appropriate funding code/index columns.

Lines 3, 6, 9, 12, 15, 18 and 21 – Net Operating Costs

For each service provider reported, enter the total net operating costs for the reporting period in the appropriate funding code/index columns.

Columns 3-7 – Lines 22-24 – Page Total Information

22. Total Expenses

Enter the sum of the amounts reported on lines 1, 4, 7, 10, 16 and 19 for each funding code and funding code index combination used.

23. Revenues

Enter the sum of the amounts reported on lines 2, 5, 8, 11, 14, 17 and 20 for each funding code and funding code index combination used.

24. Net Operating Costs

Enter the sum of the amounts reported on lines 3, 6, 9, 12, 15, 18 and 21 for each funding code and funding code index combination used.

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Columns 3-7 – Lines 25-31 – County Total Information (Last page(s) of CQR-2 only)

25. Total Expenses

On the last set of CQR-3 continuation sheets, enter the sum of the amount(s) reported on line 22 of each CQR-3 for each funding code and funding code index combination used.

26. Revenues

On the last set of CQR-3 continuation sheets, enter the sum of the amount(s) reported on line 23 of each CQR-3 for each funding code and funding code index combination used.

27. Net Operating Costs

On the last set of CQR-3 continuation sheets, enter the sum of the amount(s) reported on line 24 of each CQR-3 for each funding code and funding code index combination used.

28. Reimbursement Rate

For each funding code and funding code index combination used in columns 3-7, enter the applicable reimbursement rate for that funding code and funding code index combination on the last set of CQR-3 continuation sheets.

29. State Aid Subtotal

For each funding code and funding code index combination used in columns 3-7, enter the State Aid amount calculated by applying the reimbursement rate entered on line 28 to the amount entered on line 27 of the last set of CQR-3 continuation sheets..

30. Extra \$25,000

In the column used for funding code 001 on the last set of CQR-3 continuation sheets, LGUs with a population of 200,000 or less should calculate an additional 25% reimbursement of the net operating costs reported on line 27 up to the approved OASAS or OPWDD limit.

31. State Aid Total

On the last set of CQR-3 continuation sheets, enter the sum of the amounts reported on lines 30 and 31.

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Column 2 State Agency Total Information - Lines 1-20

Lines 1, 4, 7, 10, 16 and 19 – Total Expenses

For each service provider reported, enter the sum of the expenses reported on these lines in columns 3-7.

Lines 2, 5, 8, 11, 14, 17 and 20 – Revenues

For each service provider reported, enter the sum of the revenues reported on these lines in columns 3-7.

Lines 3, 6, 9, 12, 15, 18 and 21 – Net Operating Costs

For each service provider reported, enter the sum of the net operating costs reported on these lines in columns 3-7.

Column 2 – Page Total Information - Lines 22-24

32. Total Expenses

Enter the sum of the amounts reported on lines 1, 4, 7, 10, 16 and 19 of column 2.

33. Revenues

Enter the sum of the amounts reported on lines 2, 5, 8, 11, 14, 17 and 20 of column 2.

34. Net Operating Costs

Enter the sum of the amounts reported on lines 3, 6, 9, 12, 15, 18 and 21 of column 2.

Column 2 – County Total Information - Lines 25-31 (Last page(s) of CQR-2 only)

35. Total Expenses

On the last set of CQR-3 continuation sheets, enter the sum of the amounts reported on line 22 of each CQR-3 submitted.

36. Revenues

On the last set of CQR-3 continuation sheets, enter the sum of the amounts reported on line 23 of each CQR-3 submitted

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37. Net Operating Costs

On the last set of CQR-3 continuation sheets, enter the sum of the amounts reported on line 24 of each CQR-3 submitted.

38. Reimbursement Rate

Make no entry.

39. State Aid Subtotal

On the last set of CQR-3 continuation sheets, enter the State Aid amount calculated for each funding code and funding code index combination used in columns 3-7 by applying the reimbursement rate entered on line 28 to the amount entered on line 27.

40. Extra \$25,000

On the last set of CQR-3 continuation sheets, LGUs with population of 200,000 or less should calculate an additional 25% reimbursement of the net operating costs reported on line 27 under funding code 001.

41. State Aid Total

On the last set of CQR-3 continuation sheets, enter the sum of the amounts reported on lines 30 and 31.

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Adaptive Equipment: Devices, aids, controls, appliances or supplies of either a communication or adaptive type, determined necessary to enable the person to increase his or her ability to function in a home and community based setting with independence and safety.

Affiliate: An associate with respect to a partnership - each partner within the partnership; a corporation - each officer, director, principal stockholder and controlling person within the corporation; a natural person - each member of the person's immediate family; each partnership; and each partner of the person; each corporation in which the person or any affiliate of the person is an officer, director, principal stockholder, or controlling person.

Agency Administration: Those expenses which are not directly attributable to a specific program but rather to the overall administration of all the programs, or a support function for the agency, such as personnel, that is not specific to any particular program, service, or contract.

Amortization: The process of writing off a regular portion of the cost of an intangible asset over a fixed period of time. Refer to Appendix O - Guidelines for Depreciation and Amortization.

Arm's Length Transaction: A transaction entered into by unrelated parties, each acting in their own best interest. It is assumed that in this type of transaction, the prices used are the fair market values of the property or services being transferred in the transaction.

Asset: Property and service rights, measurable in terms of money, which the entity acquires for their economic benefit or value.

Building: The basic structure, shell and additions. The remainder is identified as fixed equipment. Land costs are not depreciable and should be excluded from building costs.

Capital Expenditure: The acquisition of both property and equipment having a useful life which extends over more than one accounting period. A capital expenditure either adds a fixed asset unit or increases the value of an existing fixed asset. Expenditures benefiting only the current year should be treated as an operating expense.

Closely allied entities (CAEs): Closely allied entities include corporations, partnerships, unincorporated associations or other bodies that have been formed or are organized to provide financial assistance and aid for the benefit of the service provider or receive financial assistance and aid from the service provider. Financial assistance and aid include engaging in fund raising activities, administering funds, holding title to real property, having an interest in personal property of any nature, and engaging in any other activities for the benefit of the service provider or the closely allied entity.

Community Support Programs (CSP revenue): Medicaid revenue that is added to the Medicaid rate of certain OMH outpatient programs in proportion to the amount of community support program state and local net deficit funding that has previously been replaced by CSP. This Medicaid revenue is regulated in law 14NYCRR Part 588.

Comprehensive Outpatient Programs (COPS revenue): Medicaid revenue that is added to the Medicaid rate of certain OMH outpatient programs in proportion to the amount of state and local net deficit funding that has previously been replaced by COPS . This Medicaid revenue is regulated in law 14NYCRR parts 592.

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Controlling Party: Any person or organization who by reason of a direct or indirect ownership interest or designated responsibility (whether of record or beneficial) has the ability, acting either alone or in concert with others with ownership interest or designated responsibility, to direct or cause the direction of the management or policies of a corporation, partnership or other entity. Neither the commissioner nor any employee of DMH, SED nor any member of a local legislative body of a county or municipality, nor any county or municipal official except when acting as the administrator of a program shall, by reason of his or her official position, be deemed a controlling party of any corporation, partnership or other entity. For SED purposes, "Controlling Party" shall have the same meaning as "less-than-arm's-length relationship" as defined in Section 200.9 of the SED Commissioner's Regulations.

Department of Mental Hygiene (DMH): The agency in New York State charged with the responsibility for providing services for the care and treatment of mental illness, developmental disabilities, alcoholism and substance abuse as well as the prevention of such conditions.

Depreciation: The process of writing off the acquisition cost of a fixed asset over the estimated useful life. Depreciation is the decline in economic potential of limited life assets originating from wear and tear, natural deterioration through interaction of the elements, and technical obsolescence. Refer to Appendix O - Guidelines for Depreciation and Amortization.

Disproportionate Share Income (DSH): Disproportionate Share Income (DSH) Legislation (Bill #5550-A, 1997-98 Budget initiative) signed by the Governor in 1997 allows for the Office of Mental Health and the Office of Alcohol and Substance Abuse Services to replace net deficit financing with Disproportionate Share Funding in Article 28 voluntary non-profit general hospitals. Payments shall not exceed such general hospital's cost of providing services to uninsured and Medicaid patients after taking into consideration all other Medical Assistance received, including disproportionate share payments made to general hospital and payments from and on behalf of such uninsured patients and shall also not exceed the amount of State Aid and Local Aid Grants for which the hospital or its successor would have been eligible pursuant to Articles 25 & 41 of the Mental hygiene Law for fiscal year 1996-97.

Expensed Adaptive Equipment: Includes the costs of all adaptive equipment purchased during the CFR reporting period with a value of less than \$5,000 or a useful life of less than two years.

Expensed Equipment: Includes the costs of all equipment purchased during the CFR reporting period with a value of less than \$5,000 or a useful life of less than two years.

Federal Grants: Sources of revenue in the form of grants received directly from the federal government to support service provider programs.

Federal Medicaid Salary Sharing: A Medicaid revenue. Through the Federal Medicaid Salary Sharing program, counties can be reimbursed for part of the cost of county staff time related to the management of certain aspects of mental health or mental retardation Medicaid Programs. (Costs associated with staff who operate medical programs or who provide direct care, are, however, not included).

Fixed Equipment: Includes attachments to buildings, such as wiring, electrical fixtures, plumbing, elevators, heating and air conditioning systems, etc. The general characteristics of this equipment

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are: a) affixed to the building and not subject to transfer; and b) minimum useful life of two years, but shorter than the life of the building to which affixed.

Fund Raising: All expenses associated with the activities a service provider may use to supplement its revenues in obtaining contributions, gifts, grants, etc. All fund raising and special events expenses (personal services, leave accruals, fringe benefits, OTPS, equipment and property) are to be included as “other programs” (column 7) on Schedule CFR-2 and the appropriate operating expenses (personal services, leave accruals, fringe benefits and OTPS) included on Schedule CFR-3, line 48.

Historical Cost: The cost at date of acquisition of an asset, less discounts plus all normal incidental costs necessary to bring the asset into existing use and location.

Immediate Family: A relationship including brother, sister, grandparent, grandchild, first cousin, aunt or uncle, spouse, parent, or child of such person, whether such relationship arises by reason of birth, marriage or adoption.

Improvement(s): A capital expenditure which extends or improves the useful life of an asset or improves it in some manner over and above the original asset. Thus, if an expenditure adds years to an asset's useful life or improves its rate of output, it would be considered an improvement. In contrast, a maintenance or repair expense is not capitalized.

In-Contract vs. Out of Contract: Programs that are approved to receive Aid to Localities net deficit funding on the Consolidated Budget Report (CBR) are designated as in-contract (i.e., utilizing one of the funding codes listed in Appendix N, except for the non-funded code 090), while programs not receiving Aid to Localities net deficit funding (i.e., utilizing funding code 090) are regarded on the CBR as out-of-contract. See Appendix Z for Policy Statement and Procedures.

Leasehold: An agreement between the lessee and the lessor specifying the lessee's rights to use the leased property for a given time at a specified rental payment.

Leasehold Improvements: Modifications or upgrades made by a lessee to leased property which revert to the lessor at the expiration of the lease term. See Appendix O for amortization rules.

Local Governmental Unit (LGU) Administration: A program category which includes all local government costs related to administering services for the mentally ill, developmentally disabled, alcohol and/or substance abuser. These costs should not include agency and program administration costs, but should include community service board costs.

Long-Term Sheltered Employment (LTSE): New York State's long-term sheltered employment appropriation funds sheltered employment services and related vocational services to eligible people with disabilities who are unable, at this time, to work in fully integrated settings. LTSE funds are recorded as revenue in the aforementioned programs. These programs are under the auspices of the Office of Mental Health and/or the Office for people with Developmental Disabilities.

Maintenance in Lieu of Rent: Expenditures should include the rent of premises or the cost to own and maintain the premises. If the building is occupied jointly with other tenants, this cost should be allocated on the basis of the service provider's proportionate share of the total usable square footage of the building.

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Medicaid: A revenue category representing payments received for services to eligible participants under the combined Federal/State program which pays for medical care for those who cannot afford it, regardless of age.

Medicare: A revenue category representing payments received for services to eligible participants under the Federal programs which pay for medical care for those 65 years old or over and/or disabled under Title II and in receipt of Social Security disability benefits for 24 months.

Mirrored Services: 100% State funding of services for consumers who do not qualify for Medicaid but are approved for state funding of the service. Not to be confused with Net Deficit Funding.

Moveable Equipment: The general characteristics of this equipment are:

- a. capable of being moved as distinguished from fixed equipment;
- b. a unit cost sufficient to justify ledger control;
- c. sufficient size and identity to make control feasible by means of identification tags; and
- d. a minimum useful life of approximately two years.

Refer to Appendix O - Guidelines for Depreciation and Amortization.

Net Deficit Funding: All revenues resulting from:

- a. direct contract with New York State Department of Mental Hygiene (DMH);
- b. contract with Local Government Unit (state and county Share);

Note: Do not include the provider share (voluntary contribution) in this amount.

Not-for-Profit Organization: A group, institution, or corporation formed for the purpose of providing goods and services under a policy where no individual (e.g., trustee) will share in any profits or losses of the organization. Profit is not the primary goal of not-for-profit entities. Profit may develop, however, under a different name (e.g., surplus, increase in fund balance). Assets are typically provided by sources that do not expect repayment or economic return. Usually, there are restrictions on resources obtained. All income and earnings will be used exclusively for the purpose of the corporation and no part shall inure to the benefit or profit of any private individual firm or corporation.

Organizational Expense: Expenditures incurred in starting a business. They include attorney's fees and various registration fees paid to State governments. The total of all the expenditures is considered to be an intangible asset. Theoretically, these expenditures may benefit the company throughout its operating life, but must be amortized. Refer to Appendix O for amortization rules.

Principal Stockholder: A person who beneficially owns, holds or has the power to vote, ten percent (10%) or more of any class of securities issued by said corporation.

Program Administration Expense: Administrative expenses directly attributable to a specific program which may include but are not limited to personal services and fringe benefits of Program Director, Billing Personnel, etc.

Related Party Transaction: A transaction between the reporting entity, its affiliates, principal owners, management and members of their immediate families and any other party with which the reporting entity may deal when one party has the ability to significantly influence management or operating

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policies of the other to the extent that one of the transacting parties might be prevented from fully pursuing its own separate interests.

Salvage Value: The amount expected to be realized upon the sale or other disposition of the asset when it is no longer useful to the program.

Site Specific Methodology: An accepted cost development and reporting methodology in which costs of programs are related to specific sites where services are provided, as opposed to aggregating and averaging costs for all sites (cost averaging).

State Grant: A revenue category which represents income from State agencies other than OASAS, OMH, OPWDD and SED.

Third Party: A revenue category which includes payments received for services to participants from private health insurance coverage such as Blue Cross, etc.

Unit of Service: The workload measure by which programs are evaluated. Units of service vary with the type of program provided.

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The following lists commonly used acronyms:

Acronym	Translation
(A)	Advocate
(P)	Practitioner
(R)	Recipient
AA/NA	Alcoholics Anonymous/Narcotics Anonymous
AAA	Area Agency on Aging
AAAs	Affirmative Action Administrators
AACAP	American Academy of Child & Adolescent Psychiatry
AACP	American Association of Community Psychiatry
AAMR	American Association on Mental Retardation
AAUAP	American Association of University Affiliated Programs
ABI	Affirmative Business/Industry
ABSS	Applied Behavioral Sciences Specialist
AC	Augmentative Communication
ACD	Alternate Care Determination or Agency for Child Development
ACDD	Accreditation Council on Developmental Disabilities
ACE	Assisted Competitive Employment
ACF	Adult Care Facility or Administration for Families and Children
ACLS	Advanced Cardiac Life Support
ACS	NYC Administration for Children's Services, Formerly Children's Protective Services
ACSW	Academy of Certified Social Workers
ACT	Assertive Community Treatment
ADA	Americans with Disabilities Act
ADC	Adult Day Care
ADD	Administration on Developmental Disabilities
ADEA	Age Discrimination in Employment Act of 1965
ADHD	Attention Deficit Hyperactivity Disorder
ADL	Activities of Daily Living (sometimes "ADL skills")
ADR	Additional Documents Request
AES	Adaptive Equipment Specialist
AFDC	Aid to Families with Dependent Children
AHA	American Heart Association

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Acronym	Translation
AHIP	America's Health Insurance Plans
AHRC	Association for the Help of Retarded Citizens or Children
AHRQ	Agency for Health Care Research and Quality
AHSCM	Adult Home Supportive Case Management
AIDS	Acquired Immune Deficiency Syndrome
AILCNY	Association of Independent Living Centers in New York, Inc.
ALFS	Aid to Localities Financial System
ALIA	Alliance of Long Island Agencies, Inc.
ALOS	Average Length of Stay
AMAP	Approved Medication Administration Personnel
AMI	Alliance on Mental Illness
AOC	Administrator on Call
AOD	Administrator on Duty
AOT	Assisted Outpatient Treatment
APA	American Psychiatric Association or American Psychological Association
APC	Ambulatory Payment Classification
APS	Adult Protective Services
ARC	Association for Retarded Citizens (formerly "Children")
ARF	Association of Rehabilitation Facilities
ARMS	Alternative Rate Methodology
ARS	Automated Rate Setting
ARTL	Agency Reduction Transfer List
ASA/O	Adolescent Sexual Abuser/Offender System
ASAP	The Alcoholism and Substance Abuse Providers of New York State or the American Society for Adolescent Psychology
ASFC	Agency Sponsored Family Care
ASL	American Sign Language
ASQ	Ages and Stages Questionnaire
ASSG	Administrative Support Services Group
ASSQ	Autism Spectrum Screening Questionnaire
AT	Assistive Technology
ATA	Assistive Technology Act of 1998
ATF	Alcoholism Treatment Facility

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Acronym	Translation
ATM	Automatic Teller Machines
AURORA	Automated User ID Request & Online Resource Authorization
AWOL	Absences Without Leave
BAF	Baseline Assessment Form
BASC	Behavior Assessment System for Children
BASER	Bureau of Adult Services Evaluation Research
BCHI	Bureau of Criminal History Information
BED&I	Bureau of Environmental Design & Improvement & Real Property Services
BERD	Behavior Event Requiring Documentation
BEWD	Bureau of Education and Workforce Development
BH	Boarding Home
BHS	Bureau of Housing Services
BIC	Bureau of Inspection and Certification
BIP	Behavior Modification Plans
BMHC	Brooklyn Mental Health Council
BOCES	Board of Cooperative Educational Services
BOE	NYC Department of Education Board of Education
BOR	NYS Board of Regents
BOV	Board of Visitors
BPD	Borderline Personality Disorder
BRPS	Bureau of Real Property Services
BSC	Balanced Scorecard
BSMHB	Baltic Street Mental Health Board
BSW	Bachelor of Social Work
BUS	Building Usage Summary
C&F	Children and Families
CAB	Consumer Advisory Board
CABI	Center for Advance Brain Imaging
CAC	Credentialed Alcoholism Counselor
CACMH	Center for the Advancement of Children's Mental Health
CADD	Computer-Aided Design & Drafting
CAE	Closely Allied Entity

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Acronym	Translation
CAFAS	Child and Adolescent Functional Assessment Scale
CAFR	Comprehensive Annual Financial Report
CAH	Care at Home
CAIRS	Child and Adult Integrated Reporting System
CAMS	Capital Asset Management System
CANS	Child and Adolescent Needs and Strengths
CANS-MH	Child and Adolescent Needs and Strengths – mental Health Instrument
CANY	The Correctional Association of New York
CAP	Client Assistance Program
CAPNET	CAPital District NETwork (provides telephone service for state agencies in the capital district)
CAPTA	Child Abuse Prevention and Treatment Act; formerly “CAPA”
CARE	Consumer Advocate Review and Evaluation
CARF	Commission on Accreditation of Rehabilitation Facilities
CAS	Central Accounting System
CASA	Computer Application Sharing Agreement
CAT Scan	Computerized Axial Tomography Scan
CBCL	Child Behavior Checklist
CBFM	Community Budget and Financial Management
CBO	Consolidated Business Office or Community-Based Organization
CBR	Consolidated Budget Report
CBT	Cognitive Behavioral therapy or Competency Based Training
CBVH	Commission for the Blind & Visually Handicapped
CCF	Council on children and Families
CCM	Comprehensive Case Management
CCR	Consolidated Claiming Report
CCRB	Civilian Complaint Review Board
CCSI	Coordinated Children’s Services Initiative
CDC	Centers for Disease Control & Prevention or Child Development Center
CDCP	Centers for Disease Control and Prevention
CDL	Commercial Drivers License
CDPC	Capital District Psychiatric Center
CDR	Continuing Disability Reviews

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Acronym	Translation
CDT	Continuing Day Treatment
CEO	Chief Executive Officer
CESQG	Conditionally Exempt Small Quantity Generator
CET	Crisis Evaluation Team or Community Evaluation Team
CFA	Comprehensive Functional Assessment
CFDA	Catalog of Federal Domestic Assistance
CFF	Consolidated Facilities File
CFO	Chief Fiscal Officer
CFR	Consolidated Fiscal Report or Code of Federal Regulations
CFS	NYS Children and Family Services
CGAS	Children's Global Assessment Scale
CHAS	Comprehensive Housing Affordable Strategy
CHAT	Childhood Autism Test or Checklist for Autism in Toddlers
CHCS	Center for health Care Strategies
CHHA	Certified Home Health Agency
CHIP	Children's Health Insurance Program
CHP	Child Health Plus
CI	Community Inclusion
CIFA	NYS Center for Information Forensics and Assurance at the University at Albany
CIN	Client Identification Number
CIO	Office of the Chief Information Officer
CISM	Center for Information Systems Management
CIT	Center for Intensive Treatment
CIT	Center for Information Technology
CLMHD	NYS Conference of Local Mental Hygiene Directors
CM	Case Management or Manager
CMAT	Children's Mobile Assessment Team
CMCM	Comprehensive Medicaid Case Management
CME	Continuing Medical Education
CMHAN	Children's Mental Health Action Network
CMHC	Community Mental Health Center
CMHS	Center for Mental Health Services or Federal Community Mental Health Services Block Grant or Community Mental Health Services

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Acronym	Translation
CMM	Community Minor Maintenance
CMMS	Computerized Maintenance Management System
CMO	Career Mobility Office
CMS	Centers for Medicaid and Medicare Services
CNDA	Confidentiality & Non-Disclosure Agreement
CNS-CREF	The Center for Neuro Skills Clinical Research and Education Foundation
Coalition	The Coalition of Voluntary Mental Health Agencies, Inc.
COBRA	Consolidated Omnibus Reconciliation Act
COC	NYS Commission of Correction
COD	Co-occurring Disorders
COIL	Coalition of Independent Living
COLA	Cost of Living Adjustment
COMPASS	Consumption, Outcome, Management Plan, Agency Self-Survey
CON	Certificate of Need
COP	Conditions of Participation or Comprehensive Outpatient Providers
COPs	Comprehensive Outpatient Providers
COQ	Consumer Opinion Questionnaire
COTA	Certified Occupational therapy Assistant
COTS ERP	Commercial Off-The-Shelf Enterprise Resource Planning Software
Covenant	Covenant House of New York
CP	Cerebral Palsy
CPA	Child Protective Agency or Certified Public Accountant
CPEOM	Center for Performance Evaluation and Outcomes Management
CPEP	Comprehensive Psychiatric Emergency Program
CPI	Consumer Price Index
CPL	Criminal Procedure Law
CPOE	Computerized Prescriber Order Entry
CPS	Child Protective Services
CPSE	Committee for Preschool Special Education
CQAIMH	Center for Quality Assessment and Improvement in Mental Health
CQC	NYS Commission on Quality of Care of the Mentally Disabled
CQCAPD	NYS Commission on Quality of Care and Advocacy for Persons with Disabilities

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Acronym	Translation
CQI	Continuous Quality Improvement
CQR	Claiming Quarterly Report
CR	Community Residence
CRBF	Cost Report Base File
CR-File	Copy of the XR file; [used to produce a cost report; where changes are made]
CRIPA	Civil rights of Institutionalized Persons Act of 1980
CRP	Children's Residential Program
CRS	Community Rehabilitation and Support
CR-SRO	Community Residence Care Single Room Occupancy
CSB	Community Services Board
CSCIC	NYS Office of Cyber Security and Critical Infrastructure Coordination
CSE	Committee for Special Education
CSEA	Civil Service Employees Association Union
CSEAP	Clerical and Secretarial Employee Advancement Program
CSP	Community Support Program (formerly CSEP) or Community Support Program
CSS	Community Support Services
CSW	Certified Social Worker
D&TC	Diagnostic & Treatment Center
DA	Developmental Aide or Dormitory Authority
DAI	Disability Advocates, Inc.
DAP	Disability Advocacy Program
DARS	Division of Administration & Revenue Support
DASNY	Dormitory Authority of the State of New York
DBMS	Database Management System
DC	Developmental Center
DCAS	Department of Citywide Administrative Services
DCC	Day Care Center
DCJS	NYS Division of Criminal Justice Services
DCN	Document Control Number
DD	Developmental Disabilities or Developmentally Disabled
DDC	Department of Design & Construction
DDP	Developmental Disabilities Profile
DDPC	NYS Developmental Disabilities Planning Council

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Acronym	Translation
DDSO	Developmental Disabilities Service Office
DEA	Data Exchange Agreement or US Drug Enforcement Agency
DEP	Department of Environmental Protection
DFA	NYS Department of Family Assistance (formerly Department of Social Services)
DFAS	(Deputy) Director of Facility Administrative Services
DFTA	NYC Department for the Aging
DHCR	NYS Division of Housing & Community Renewal
DHHS	Federal Department of Health and Human Services
DHMH	NYC Department of Health and Mental Hygiene
DIG	Data Infrastructure Grant
DIRT	Data Integrity Review Team Visits
DLSW	Direct Local Sheltered Workshop
DME	Durable Medical Equipment
DMH	New York State Department of Mental Hygiene
DMHA	Division of Mental Health and Addiction
DMHIS	Dept. Mental Hygiene Information system
DMHMR	NYC Department of Mental Health, Mental Retardation & Alcoholism Services
DMV	Department of Motor Vehicles
DNR	Do Not Resuscitate
DNS	Domain Name Service
DOB	NYS Division of the Budget
DOC	Departmental Operations Center
DOH	Department of Health
DOJ	Us Department of Justice
DOL	Department of Labor
DOS	Department of Sanitation
DOT	NYS Department of Transportation
DPC	Discharge Planning Committee
DPCA	NYS Division of Probation and Correctional Alternatives
DPR	Department of Parks and Recreation
DPS	Diagnostic Predictive Scales
DQA	Director of Quality Assurance or Division of Quality Assurance

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Acronym	Translation
DRC	Diagnostic and Research Clinic
DRG	Diagnostic Related Group
DS	District Superintendent
DSH	Disproportionate Share
DSM-IV	Diagnostic and Statistical Manual, (4 th edition)
DSS	Department of Social Services
DSW	Director Sheltered Workshop
DT	Day Treatment
DVA	Division of Veterans Affairs
DVE	Diagnostic Vocational Evaluation
EAP	Employee Assistance Program
EBPs	Evidence Based Practices
EBT	Electronic Benefit Transfer
EBTDC	Evidenced-Based Treatment Dissemination Center
ECDC	Early Childhood Direction Centers
ECEC	Early Childhood Education Center
ECIA	Education Consolidation Improvement Act
ECRG	Emergency Communications Resource Guide
ECT	Electroconvulsive Therapy
EDGAR	Education Department General Administrative Regulations
EDI	Electronic Data Interchange
EDP	Emotionally Disturbed Person
EEOC	Equal Employment Opportunity Commission
EI	Excess Income or Early Intervention
EIS	Environmental Impact Statement
EISEP	Expanded In-Home Services for Elderly Persons
EMOD	Environmental Modification
Empathize	Listen
EMS	Emergency Medical Services
EMSS	Emergency Medical Services System
EO	Executive Order
EOB	Extended Observation Bed
EOC	Emergency Operations Center

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Acronym	Translation
eProjects	Project Management System
EPSDT	Early Periodic Screening & Diagnostic Treatment Program
ERD	Entity Relationship Diagram
ERGO	Energy Reporting and Graphing Online
ERP	Enterprise Resource Planning Software
ESDC	NYS Empire State Developmental Corporation
ETAC	Enterprise Technical Architecture Committee
EW	Extended Warranties
FA	Family Assistance
FAS	Fetal Alcohol Syndrome
FBA	Functional Behavioral Assessments
FBT	Family-Based Treatment
FBTP	Family-Based Treatment Program
FC	Family Care
FCH	Family Care home
FDA	US Food and Drug Administration
FDC	Family Development Credentialing
FECS	Federation Employment and Guidance Service, Inc.
FEMA	Federal Emergency Management Agency
FERPA	Family Educational rights and Privacy Act
FFC	Foster Family Care
FFP	Federal Financial Participation
FFS	Fee For Service
FFY	Federal Fiscal Year
FH	Fountain House
FHA	Fair Housing Act
FICC	Facility Information Center Coordinator
FinTrans	Financial Transaction System
FIS	Financial Information System
FLSA	Fair Labor Standards Act
FMLA	Family and Medical Leave Act
FMS	Financial Management System
FOIA	Freedom of Information Act

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Acronym	Translation
FOIL	Freedom of Information Law
FRE	Facility Real Estate
FSS	Family support Services or Federal Salary Sharing
FTE	Full Time Equivalent
FUAF	Follow-up Assessment Form
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GAAS	Generally Accepted Auditing Standards
GAF	Global Assessment of Functioning
GASB	Government Accounting Standards Board
GED	General Equivalency Diploma
G-I-N	Gross-income-net
GME	Graduate Medical Education
GOER	NYS Governor's Office of Employee Relations
HASA	HIV/AIDS Service Administration
HAVA	Help America Vote Act
HAZMAT	Hazardous Materials Communications Training
HBCI	Home-Based Crisis Intervention
HCBS	Home and Community Based Services (sometimes "W", for –Waiver, is appended)
HCFA	Health Care Financing Administration
HCRA	Health Care Reform Act
HFA	New York State Housing Finance Agency
HFC	Hospital Forensic Committee
HHC	NYC Health and Hospitals Corporation
HHS	US Department of Health and Human Services
HHS IG	HHS Inspector General
HIM	Health Information Management
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIT	Health Care Information Technology
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
HR	Human Resources

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Acronym	Translation
HRA	NYC Human Resources Administration
HRISnet	Human Resources Information System
HRSA	Health Resources and Services Administration
HSA	Health Systems Agency
HTML	HyperText Markup Language
HUD	U.S. Department of Housing and Urban Development
HVAC	Heating, Ventilating and Air Conditioning
HW	Hazardous Waste
I&R	Interns & Residents
IAC	Inter-Agency Council of Mental Retardation and Developmental Disabilities Agencies, Inc.
IAH	Impacted Adult Homes
IBR	Institute for Basic Research in Developmental Disabilities
IC	Incident Commander
ICC	Individualized Care Coordination
ICCD	International Center for Clubhouse Development
ICF	Intermediate Care Facility
ICF/DD	Intermediate Care Facility for the Developmentally Disabled
ICF/MR	Intermediate Care Facility for the Mentally Retarded
ICM	Intensive Case Management
ICP	Indirect Cost Proposal or Intermediate Care Program
ICR	Individual Case Review
ICS	Incident Command System
IDA	Individuals with Disabilities Education Act
IDEA	Individuals with Disabilities Education Act
IDEIA	Individuals with Disabilities Educational Improvement Act (formerly IDEA)
IEP	Individualized Education Plan or Individualized Educational Program
IFSP	Individualized Family Service Plan
ILC	Independent Living Center
INT	Intensive Supportive
IOC	Inspection of Care; Involuntary Outpatient Commitment
IOCC	Inter-Office Coordinating Council
IOM	Institute of Medicine

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Acronym	Translation
IOT	Involuntary Outpatient Treatment
IPOP	Individualized Plan of Protective Oversight
IPP	Individual Program Plan
IPR	Independent Professional Review
IPRT	Intensive Psychiatric Rehabilitation Treatment
IR	Intensive Rehabilitation
IRA	Individual Residential Alternative
IRF	Inpatient Rehabilitation Facility
IRWE	Impairment-Related Work Expense
ISE	Individualized Service Environment
ISER	Information Security Event Response
ISL	Information Security Liaison
ISO	Information Services Office
ISP	Individual Service Plan
ISPM	Individual Services Planning Model
ISS	Individual Support Services; also Information Support Services
IT	Interdisciplinary Team or Information Technology
ITAC	Information Technology Advisory Committee
ITT	Interdisciplinary Treatment Team
ITU	Intensive Treatment Unit
IUR	Independent Utilization Review
IWRP	Individual Written Rehabilitation Plan
JAIBG	Federal Juvenile Accountability Incentive Block Grant
JAMA	Journal of the American Medical Association
JCAHO	Joint Commission on the Accreditation of Health Care Organizations
JD	Juris Doctor
JHS	Junior High School
JJ	Juvenile Justice
LA	Local Assistance
LAN	Local Area Network
LATS	Leave and Accrual Tracking System
LCAT	Licensed Creative Arts Therapist
LCED	Level of Care Eligibility Determination

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Acronym	Translation
LCSW	Licensed Clinical Social Worker
LD	Learning Disability, Learning Disabled
LDANYS	Learning Disabilities Association of NYS
LDM	Logical Data Model
LDSS	Local Department of Social Services District
LEA	Local Education Agency
LEAP	Labor Education Action Programs
LEC	Load, Edit, Calculate (a dBase command)
LFY	Local Fiscal Year
LGU	Local Governmental Unit
LHA	Local Housing Authority
LHCSA	Licensed Home Care Services Agency
LMS	Learning Management System
LMSW	Licensed Master Social Worker
LOC	Level of Care
LOS	Line-of-Sight or level of supervision
LRE	Least Restrictive Environment
LSC	Life Safety Code
LTSE	Long Term Sheltered Employment
M/C	Management/Confidential
MA	Medicaid or Master of Arts
MADI	Mood and Anxiety Disorders Institute
MAR	Medication Administration Record
MAYS1-2	Massachusetts Youth Screening Instrument-Second Version
MCFFA	Medical Care Facilities Finance Agency
M-CHAT	Modified Checklist for Autism in Toddlers
MCO	Managed Care Organization
MCP	Managed Care Provider
MCSE	Microsoft Certified System Engineer
MD	Medical Doctor
MDU	Multiple Disability Unit
MedSAP	Medication Self-Administration Program
MGP	Medication Grant Program

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Acronym	Translation
MH	Mental Health
MHA	Mental Health Association
MHANYS	Mental Health Association of New York State
MHARS	Mental Health Automated Record System
MHL	Mental Hygiene Law
MHLS	Mental Hygiene Legal Service
MHPD	Mental Health Provider Data Exchange
MHSC	Mental Health Services Council
MHSIP	Mental Health Statistics Improvement Program
MHTA	Mental Health Therapy Aide
Mi/MR	Mental Illness/Mental Retardation
MICA	Mentally Ill Chemical Abusers
Middle	Elementary
MIS	Management Information Systems
MISCC	Most Integrated Setting Coordinating Council
MMIS	Medicaid Management Information System
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MPH	Master of Public Health
MRB	Medical Review Board
MRDDAC	Mental Retardation & Developmental Disabilities Advisory Council
MRI	Magnetic Resonance Imaging
MRN	Minority Regional Network
MS	Middle School
MSSW	Master of Science in Social Work
MSW	Master of Social Work
NAMI	National Alliance on Mental Illness
NAPAS	National Association of Protection and Advocacy Systems, Inc.
NARPA	National Association for Rights Protection and Advocacy
NASDDDS	National Association of State Directors of Developmental Disabilities Services
NASMHPD	National Association of State Mental Health Program Directors
NCCBH	National Council for Community Behavioral Healthcare
NCLB	No Child Left Behind

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Acronym	Translation
NCP	National Council on Disability
NDF	Net Deficit Funding
NF	Nursing Facility
NFP	Not-for-Profit Organization
NGC	National Guideline Clearinghouse
NHIS	National Health Interview Survey
NHSC	National Health Service Corps
NIA	National Institute on Aging
NICU	Neonatal Intensive Care Unit
NIDRR	National Institute of Disability & Rehabilitation Research
NIE	National Institute of Education
NIH	National Institute of Education
NIIMS	National Interagency Incident Management System
NIMBY	Not in my back yard
NIMH	National Institute of Mental Health
NIMRS	New Incident Management Reporting System
NIQRS	New Initiatives Quarterly Reporting System
NKI	Nathan Kline Institute for Psychiatric Research
NLM	National Library of Medicine
NOD	Notice of Determination or Notice of Discipline
NORC	Naturally occurring retirement communities
NOS	Not Otherwise Specified
NOT	Notice of Termination
NP	Nurse Practitioner
NPC	Neighborhood Preservation Corporation
NPI	National Provider Identifier
NPP	Notice of Privacy Practices
NPS	Non-Personal Services
NRI	National Association of State Mental Health Program Directors Research Institute, Inc.
NSSP	National Strategy for Suicide Prevention
NYAPRS	New York Association of Psychiatric Rehabilitation Services
NYCDH&MH	New York City Dept. of Health and Mental Hygiene

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Acronym	Translation
NYCDMH	New York City Dept. of Mental Health, Mental Retardation and Alcoholism Services
NYCDOH&MH	New York City Department of Health and Mental Hygiene
NYCRO	New York City Regional Office
NYCRR	New York Codes, Rules, and Regulations
NYFMS	New York Financial Management System
NYISER	New York Interagency Supported Employment Report
NYLPI	New York Lawyers for the Public Interest, Inc.
NYPI	NYS Psychiatric Institute
NYRSA	New York State Rehabilitation Association
NYS OHIP	New York State Campaign for Mental Health Housing
NYSACRA	NYS Association of Community and Residential Agencies.
NYSARC	Association for Retarded Citizens
NYS-CARES	New York State-Creating Alternatives in Residential environments and Services
NYSCRR	NYS Codes, Rules and Regulations
NYSNA	NYS Nurses Association
NYSPA	NYS Psychiatric Association
NYSRA	NYS Rehabilitation Association
NYSSAC	NYS Society for Autistic Citizens
NYSTEP	NYS Electronic Personnel System
OAA	Older Americans Act
OAPwD	NYS Office of Advocate for Persons with Disabilities
OAS	Outside Agency Space Summary
OASAS	NYS Office of Alcoholism and Substance Abuse Services
OASH	Office of Assistant Secretary of Health
OBRA	Omnibus Budget Reconciliation Act
OCDMH	Onondaga County Department of Mental Health
OCFS	Office of Children and Family Services
OCM	Onondaga Case Management
OCR	Office of Civil Rights
OEF	Operation Enduring Freedom
OEOD	Office of Equal Opportunity Development

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Acronym	Translation
OFA	NYS Office for the Aging
OFT	Governor's Office for Technology
OFY	OMH Fiscal Year
OGS	NYS Office of General Services
OHC	Outside Hospital Care
OHCDs	Organized Health Care Delivery System
OHEL	OHEL Children's Home and Family Services
OHSM	Office of Health Systems Management
OIF	Operation Iraqi Freedom
OISE	Ongoing Integrated Supported Employment
OLAP	Ongoing Integrated Supported Employment
OMCE	Organization of Management Confidential Employees
OMH	Office of Mental Health
OMHFT	OMH Financial Transaction
OPWDD	Office for People with Developmental Disabilities
OPM	Office of Personnel Management
OPMC	NYS Department of Health Office of Professional Medical Conduct
OPPS	Out-Patient Prospective Payment System
OPTS	Options for People Through Services
OQI	Other Qualifying Instrument
ORS	Ongoing Rehabilitation and Support
ORYX	Not an acronym, but refers to the JCAHO required performance measurement system
OSC	NYS Office of the State Comptroller
OSERS	Office of Special Education & Rehabilitation Services
OSES	NYS Office for Special Education Services
OSHA	US Occupational Safety & Health Administration
OT	Occupational Therapy
OTPS	Other Than Personal Services
OTPT	Out-Patient Unit
OTR	Registered Occupational Therapist
OVR	Office of Vocational Rehabilitation
P&A	Protection and Advocacy System

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Acronym	Translation
P/PM	Policy & Procedures Manual
PA	Physician's Assistant; Provider Agreement; Public Assistance
PAAT	Protection and Advocacy for Assistive Technology
PABSS	Protection and Advocacy for Beneficiaries of Social Security
PAC	Products of Ambulatory Care; Political Action Committee
Padavan Law	Law governing site selection of community residential facilities
PADD	Protection and Advocacy for the Developmentally Disabled
PAI	Patient Assessment Instrument
PAIMI	Protection and Advocacy for Individuals with Mental Illness (formerly "PAMII")
PAIR	Protection and Advocacy for the Individual Rights of persons with disabilities
PAR	Prior Approval Review or Position Analysis Report
PAS	Program Assignment Summary or Preliminary Allocation Summary
PASARR	Preadmission Screening and Annual Resident Review
PASS	Plan for Achieving Self Support
PAT	Personal Adjustment Training
PATBI	Protection and Advocacy for Individuals with Traumatic Brain Injury
PATH	Projects for Assistance in Transition from Homelessness
PAVA	Protection and Advocacy for Voter Access
PaySR	Payroll Replacement System
PC	Patient council or Psychiatric Center or Personal Computer
PCP	Primary Care Physician or Person-Centered Planning
PCR	Payment-to-Cost Ratio
PCS	Patient Characteristics Study
PDD	Pervasive Developmental Disorder (sometimes with "NOS"-not otherwise specified-annexed)
PDDST	Pervasive Developmental Disorder Screening Test
PDF	Portable Document Format
PDG	Program Development Grant
PDP	Prescription Drug Plan
PE	Probably Efficacious
PECS	Picture Exchange Communication System
PEDS	Parents' Evaluation of Evaluation Status
PEF	Public Employees Federation Union

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Acronym	Translation
PEM	Psycho-educational model
PFCRA	Program Fraud Civil Remedies Act
PHI	Protected health Information
PHP	Permanent Housing Program
PHS	Public Health Service
PHSP	Prepaid Health Services Plan
PIA	Patient Income Account or Personal Incidental Allowance
PID	Project Information Data
PME	Office of Performance Measurement and Evaluation
PRO	Patient Resource Office
PROS	Personalized Recovery Oriented Services
PRU	Program Reporting Unit
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996
PS	Public School
PS/PSC	Personal Service/Personal Service Coordinator
PSA	Protective Services for Adults (also “APS”)
PSC	Pediatric Symptom Checklist or Personal Service Coordinator
PSWP	Public Service Workshop Programs
PSYCKES	Psychiatric Services and Clinical Knowledge Enhancement System
PT	Primary therapist, or Physical Therapy or Therapist
PTA	Parent-Teacher Association
PTB	Promotion Test Battery
PTSD	Post-traumatic Stress Disorder
PTSP	Public Service Training Program
PWS	Prader-Willi Syndrome, a rare genetic disorder affecting the hypothalamus
QA	Quality Assurance
QCC	Quality of Care Commission (same as “CQC”)
QI	Quality Improvement
QMRP	Qualified Mental Retardation Professional
QSR	Quarterly Service Report
R/E	Recipient Restriction Exception Code
RAS	Receiving Entity Authorized Signatory
RBITU	Regional Behavioral Intensive Treatment Unit

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Acronym	Translation
RBTU	Regional Behavioral Treatment Unit
RCA	Root Cause Analysis
RCCA	Residential Care Center for Adults
RCE	Reasonable compensation Equivalent (use for Physician salary inclusion for Part B)
RCRA	Waste Characterization and Disposal
RDA	Records Disposition Authorization
RFA	Request for Application
RFB	Request for Bid
RFI	Request for Information
RFID	Radio Frequency Identification
RFMH	Research Foundation for Mental Hygiene
RIV	Reinvestment
RN	Registered Nurse
RPC	Residential Program Counselor or Rural Preservation Corporation
RPI	Residential Program Indicators
RPQI	Rational Pharmacotherapy Quality Improvement Initiative
RRTC	Rehabilitation Research & Training Center
RSFO	Revenue Support Field Office
RSVP	Retired Senior Volunteer Program
RTC	Residential Treatment Center
RTF	Residential Treatment Facility
RUGS	Resource Utilization Group System
RV	Ratio Value
RVU	Relative Value Units-the amount of expense Medicaid is willing to reimburse OMH for supplies/services rendered
Rx	Prescription
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPA	NYS Administrative Procedure Act
SARA	NYS State Archives and
SBIT	School-Based Intervention Teams
SC	Service Coordinator
SCA	Standards Compliance Analyst
SCAA	Schuyler Center for Analysis and Advocacy

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Acronym	Translation
SCIP	Strategies for Crisis Intervention & Prevention
SCIP-R	Strategies for Crisis Intervention & Prevention-Revised
SCM	Supportive Case Management
SCOC	NYS Commission of Correction
SCP	Senior Companion Program
SCQ	Social Communication Questionnaire, formerly the Autism Screener Questionnaire or ASQ
SCTA	Secure Care Treatment Aide or NY Surrogate's Court Procedure Act
SD	Self Determination
SDMC	Surrogate Decision-Making Committee
SDQ	Strength and Difficulties Questionnaire
SED	NYS Education Department or Serious Emotional Disturbance or Seriously Emotionally Disturbed
SEFA	State Employees Federated Appeal
SEIT	Special Education Itinerant Teacher
SEMO	State Emergency Management Office
SEQRA	NYS Environmental Quality Review Act
SER	Security Reporting
SES	Socio-economic status
SETRC	Special Education Training & Resource Center
SFL	NYS Finance Law
SHNNY	Supportive Housing Network of New York
SHSC	NYS Health Services Corps.
SI	Special Investigator or Investigation
SIB	Self-Injurious Behavior
SILC	Statewide Independent Living Council
Sit-Stat	Determination of the present status of the situation
SIV	Self-Inflicted Violence
SLP	Speech/Language Pathology
SMHP	School Mental Health Project
SMI	Serious Mental Illness
SMP	Strategic Management Plan
SNA	Safety Net Assistance
SNAP	Services Now for Adult Patients Program

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Acronym	Translation
SNF	Skilled Nursing Facility
SNP	Special needs plan
SNT	Supplemental Needs Trust
SOCR	State Operated Community Residence
SOD	Statement of Deficiency
SODAS method	S-Situation, O-Options, D-Disadvantages, A-Advantages, S-Solution
SODH	State-Operated Day Habilitation
SOFA	NYS Office for the Aging
SOICF	State-Operated Intermediate Care Facility
SOIRA	State-Operated Individual Residential Alternatives
SOLQ	State On-Line Query Audit Process
SORA	Sex Offender Registration Act
SORCCA	State Operated Residential Care Center
SOTP	Sex Offender Treatment Program
SP	Speech Pathology
SPARCS	DOH-Statewide Planning and Research Cooperative System
SPEAK	Suicide Prevention Education and Awareness Kits
SPMI	Seriously and Persistently Mentally Ill
SPOA`	Single Point of Accountability
SPOE	Single Point of Entry
SPT	Supportive
SPV	Supervised
SQG	Small Quantity Generator
SRC	State Rehabilitation Council
SRO	Single Room Occupancy
SRU	Small Residential Unit
SSA	Social Security Administration
SSD	Social Security Disability
SSDI	Social Security Disability Insurance
SSHSP	School Supportive Health Services Program
SSI	Supplemental Security Income
SSO	Desktop Single Sign On

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Acronym	Translation
SSQ	Support Services Summary
STAR	Special Targeted, Abbreviated Review
STEPS	Solutions to End Psychiatric Shortages
TABS	Tracking and Billing System or Temperament and Atypical Behavior Scale
TACT	Tracking for AOT Cases and Treatments
TADA	NYS Temporary and Disability Assistance
TANF	Temporary Assistance for Needy Families
TASH	The Association for Persons with Severe handicaps
TBI	Traumatic Brain Injury
TBISCC	Traumatic Brain Injury Services Coordinating Council
TDD	Telecommunication Device for the Deaf
TE/SE	Transitional Employment/Supported Employment
TEP	Transitional Employment Placement
TERPA	The Assistive Technology Act of 1998
TF	Transitional Funding
TFCR	Teaching Family Community Residence
TFH	Teaching Family Home
TFIP	Task Force on Integrated Projects
THP	Transitional Housing Program
TLA	Time Limited Admission
TM	Transitional Management
TMAP	Texas Medication Algorithm Project
TOS	Type of Service
TPHI	Third Party Health Insurance
TRAID	Technology-Related Assistance for Individuals with Disabilities Act
TRO	Temporary Restraining Order
TTL	Treatment Team Leader
TTY	Teletypewriter
TUBS	Temporary Use Beds
TWWIA	Ticket to Work and Work Incentives Improvement Act
Tx	Treatment
UCEDD	University Centers for Excellence in Developmental Disabilities
UCPA	United Cerebral Palsy Association

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Acronym	Translation
UCR	Uniform Case Record
UJC	Urban Justice Center, Mental Health Project
UPK	Universal Pre-K
UR	Utilization Review
URC	Uniform Reporting Code or Component
UW	Universal Waste
VA	Veterans Administration
V-DISC	Voice Diagnostic Interview Schedule for Children
VESID	Vocational and Educational Services for Individuals with Disabilities
VOCR	Voluntary Operated Community Residence
VODH	Voluntary Operated Day Habilitation
VOIRA	Voluntary Operated Individualized Residential Alternative
VR	Vocational Rehabilitation
VRWS	Voluntary Reduction in Work Schedule
WAN	Wireless Area Network
WAT	Work Adjustment Training
WE	Well-established
WHO	World health Organization
WIC	Women, Infants and Children
WMS	Welfare Management System
WNYCCP	Western New York Care Coordination Program
WORC	Working Organization for Retarded Children and Adults
WSM	Wellness Self Management
WTI	Working Toward Independence
YAI	Young Adult Institute
YAI/NIPD	Young Adult Institute National Institute for People with Disabilities

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New York State Counties:

<i>County</i>	<i>Code</i>	<i>County</i>	<i>Code</i>
Albany	01	Niagara	32
Allegany	02	Oneida	33
Bronx	03	Onondaga	34
Broome	04	Ontario	35
Cattaraugus	05	Orange	36
Cayuga	06	Orleans	37
Chautauqua	07	Oswego	38
Chemung	08	Otsego	39
Chenango	09	Putnam	40
Clinton	10	Queens	41
Columbia	11	Rensselaer	42
Cortland	12	Richmond	43
Delaware	13	Rockland	44
Dutchess	14	St. Lawrence	45
Erie	15	Saratoga	46
Essex	16	Schenectady	47
Franklin	17	Schoharie	48
Fulton	18	Schuyler	49
Genesee	19	Seneca	50
Greene	20	Steuben	51
Hamilton	21	Suffolk	52
Herkimer	22	Sullivan	53
Jefferson	23	Tioga	54
Kings	24	Tompkins	55
Lewis	25	Ulster	56
Livingston	26	Warren	57
Madison	27	Washington	58
Monroe	28	Wayne	59
Montgomery	29	Westchester	60
Nassau	30	Wyoming	61
New York	31	Yates	62

Statewide – OMH Budgets and Claims Only

- OMH Statewide Contracts (OMH Only) – Use County Code 63 (January to December) or 64 (July to June)
- OMH Legislative Special Projects (OMH Only) - Use County Code 64
- All NYC boroughs for OMH – Use County Code 31

Non-New York State Counties:

- All Non-New York State Counties – Use County Code 80

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Not included in this manual.

Please see the Consolidated Fiscal Reporting and Claiming Manual.

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Below is an alphabetical listing of program types and the corresponding codes grouped by service type. Following this alphabetic list is a numeric list of program definitions and the corresponding codes.

Service providers who operate more than one certified chemical dependence site must report each site separately (in accordance with the approved budget) by indexing the appropriate program code as indicated in the examples below:

Example: A service provider operating an outpatient medically supervised chemical dependence clinic with three certified sites would report program codes 3520-00, 3520-01, 3520-02.

Program Name	Service Type	Program Code
Crisis		
Medically Supervised Withdrawal Services – Inpatient/Residential	Crisis	3039
Medically Supervised Withdrawal Services – Outpatient	Crisis	3059
Medically Managed Detoxification	Crisis	3500
Medically Monitored Withdrawal	Crisis	3510
Inpatient		
Chemical Dependence Inpatient Rehabilitation Services	Inpatient	3550
Residential Chemical Dependency Program for Youth (Short-Term)	Inpatient	4030
Methadone		
Methadone-to-Abstinence – Outpatient	Methadone	0605
Methadone Maintenance – Residential	Methadone	2030
Methadone Maintenance – Outpatient	Methadone	2050
KEEP Units – Prison – Methadone	Methadone	2110
KEEP Units – Outpatient – Methadone	Methadone	2150
Methadone-to-Abstinence – Residential	Methadone	6030
Methadone-to-Abstinence – Day Service	Methadone	6040
Outpatient		
Outpatient Chemical Dependence for Youth	Outpatient	0140
Compulsive Gambling Treatment	Outpatient	2780
Medically Supervised Outpatient	Outpatient	3520
Enhanced Medically Supervised Outpatient	Outpatient	3528
Outpatient Rehabilitation Services	Outpatient	3530
Enhanced Outpatient Rehabilitation Services	Outpatient	3538
Specialized Services Substance Abuse Programs	Outpatient	4045
Prevention		
Underage Drinking Prevention	Prevention	0507

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Program Name	Service Type	Program Code
Compulsive Gambling Education, Assessment & Referral Services	Prevention	2790
Community Mobilization	Prevention	3001
Prevention Resource Centers	Prevention	3100
Chemical Dependence Prevention Services	Prevention	5550
Program Support		
Support Services - Educational	Program Support	4074
Community Services	Program Support	4075
Resource	Program Support	4077
Program Administration	Program Support	4078
Legislative Member Item	Program Support	4778
Recovery		
Shelter Plus Care Housing	Recovery	3070
Shelter Plus Care Case Management	Recovery	3078
NY NY III: Post-Treatment Housing	Recovery	3270
NY NY III: Housing for Persons at Risk of Homelessness	Recovery	3370
Permanent Supported Housing	Recovery	3470
Recovery Community Centers	Recovery	3970
Residential		
Residential Rehabilitation Services for Youth (RRSY)	Residential	3551
Intensive Residential	Residential	3560
Community Residential	Residential	3570
Supportive Living	Residential	3580
Residential Chemical Dependency Program for Youth (Long-Term)	Residential	4060
Treatment Support		
Job Placement Initiative	Treatment Support	0465
Case Management	Treatment Support	0810
Criminal Justice Clinical Case Management	Treatment Support	0840
Local Governmental Unit (LGU) Administration	Treatment Support	0890
Managed Addiction Treatment Services (MATS)	Treatment Support	3810
Vocational Rehabilitation	Treatment Support	4072
Dual Diagnosis Coordinator	Treatment Support	5990

0140 - Outpatient Chemical Dependence for Youth

Such programs serve youth between the ages 12 and 18 by providing a drug-free setting supporting abstinence from alcohol and/or other substances of abuse. Active treatment is rendered through multi-disciplinary clinical services designed to assist the youth in achieving

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and maintaining an abstinent lifestyle and to serve youth whose normal adolescent development, in one or more major life areas, has been impaired as a result of the use of alcohol and/or other substances by a parent or significant other.

Units of Service:

Visit 30 minutes-less than two hours: A period of scheduled participation by a client which includes the receipt of one or more types of treatment services for at least 30 minutes but less than two hours in duration.

Visit two hours-less than four hours: A period of scheduled participation by a client which includes the receipt of one or more types of treatment services for at least two hours but less than four hours in duration.

Visit of four or more hours: A period of scheduled participation by a client which includes the receipt of one or more types of treatment services for at least four hours in duration.

Off-Premises Treatment Visits: A period of direct evaluation, therapy or counseling provided by an ambulatory alcoholism treatment program to a client in his or her home or convenient place thereto when the client is temporarily or intermittently unable to be served at the alcoholism treatment program premises. Visits should extend at least 30 minutes.

Socialization/Recreation Visit: A period of attendance in an alcoholism program or on the premises thereof during which only companionship, social activity, recreation or a combination thereof is received by the client.

0465 - Job Placement Initiative

Vocational rehabilitation focusing on job referrals and placement.

Unit of Service: None

0507 - Underage Drinking Prevention

Activities designed to decrease underage drinking.

Unit of Service: None

0605 - Methadone-to-Abstinence – Outpatient

Methadone treatment delivered on an ambulatory basis in gradually decreasing doses to the point of abstinence, followed by continued drug-free treatment.

Unit of Service: Visits

0810 - Case Management

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Activities aimed at linking the client to the service system and at coordinating the various services in order to achieve a successful outcome. The objective of case management in a mental health system is continuity of care and service. Services may include linking, monitoring and case-specific advocacy.

Linking: The process of referring or transferring a client to all required internal and external services that include the identification and acquisition of appropriate service resources.

Monitoring: Observation to assure the continuity of service in accordance with the client's treatment plan.

Case-Specific Advocacy: Interceding on the behalf of a client to assure access to services required in the individual service plan. Case management activities are expediting and coordinative in nature rather than the primary treatment services ordinarily provided by a therapist.

Case management services are provided to enrolled clients for whom staff are assigned a continuing case management responsibility. Thus, routine referral would not be included unless the staff member making the referral retains a continuing active responsibility for the client throughout the system of service.

Units of Service: None

0840 - Criminal Justice Clinical Case Management

Activities aimed at linking the client to the chemical dependency treatment and recovery service system and coordinating various other services in order to achieve successful outcomes for the criminal justice population to be impacted by Drug Law Reform, judicial and other diversion programs. The objective of case management is continuity of care and service. Case management services may include assessment and planning, linking, monitoring and advocacy.

Assessment and Planning: Assessment is the determination of service needs to meet the individualized treatment and recovery plan and compliance with conditions set forth by criminal justice stakeholders. Following the determination of service needs, planning involves the integration and coordination of the treatment and recovery needs across interdisciplinary and coordinated services.

Linking: Linking is the process of referring or transferring a client to all required internal and external services which include the identification and acquisition of appropriate service resources. Service resources may include housing, vocational, child care services, recovery supports and other need services.

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Monitoring: Monitoring is the periodic and systematic observation of a client's progress to assure the continuity of services in accordance with the client's treatment plan and any diversion-specific requirements.

Advocacy: Interceding on behalf of a client to assure access to services required in the individual service plan.

Units of Service: None

0890 - Local Governmental Unit (LGU) Administration

The Local Governmental Unit is defined in Article 41 of the Mental Hygiene Law. This program category includes all local government costs related to administering mental hygiene services that are provided by a local government or by a voluntary agency pursuant to a contract with a local governmental unit. LGU Administration is funded cooperatively by OASAS, OMH and/or OPWDD. As such, this program is reported as a shared program on the core schedules (CFR-1 through CFR-6) of the CFR. LGU Administration expenses and revenues related to each State Agency are reported on State Agency specific claiming schedules (DMH-2 and DMH-3). **Note:** This program type is exempt from the Ratio Value allocation of agency administration.

Units of Service: None

2030 - Methadone Maintenance – Residential

Methadone treatment programs (MTPs) that administer methadone by prescription, in conjunction with a variety of other rehabilitative assistance in a residential setting, to control the physical problems associated with heroin dependence and to provide the opportunity for patients to make major life-style changes over time.

Units of Service: Patient Days

2050 - Methadone Maintenance – Outpatient

Methadone treatment delivered primarily on an ambulatory basis, with most programs located in either a community or hospital setting. Methadone is administered daily at a stabilized dose over an extended period of time.

Units of Service: Visits

2110 - KEEP Units – Prison – Methadone

Methadone treatment delivered in a prison setting. KEEP is an interim (not more than 180 days) protocol that provides intensive medical and support services in order to evaluate the long-term treatment needs of patients

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Units of Service: Visits

2150 - KEEP Units – Outpatient – Methadone

Methadone treatment delivered on an ambulatory basis. KEEP is an interim (not more than 180 days) protocol that provides intensive medical and support services in order to evaluate the long-term treatment needs of patients

Units of Service: Visits

2780 - Compulsive Gambling Treatment

To provide outpatient treatment to compulsive gamblers designed to reduce symptoms, improve functioning and provide ongoing support. A compulsive gambling treatment program shall provide assessment and treatment planning specific to compulsive gambling, screening and referral for other problems, financial management planning, connection to self help groups for compulsive gamblers, individual, group and family therapy specific to this diagnosis and crisis intervention.

Units of Service: Visits

2790 - Compulsive Gambling Education, Assessment and Referral Services

Promising prevention programs, activities and strategies that are targeted to decrease risk factors and increase protective factors related to problem gambling behaviors.

Units of Service: None

3001 - Community Mobilization

To bring science/evidence-based prevention strategies to locally identified risks and protective factors through local coalitions that develop strategic action plans. OASAS supports this initiative with a six-phase training process, using certified trainers and provision of technical assistance.

Units of Services: None

3039 - Medically Supervised Withdrawal Services – Inpatient/Residential

As defined in Part 816 of OASAS' regulations, medically supervised withdrawal services provided in an inpatient or residential setting must be provided under the supervision and direction of a licensed physician, and shall include medical supervision of persons undergoing moderate withdrawal or who are at risk of moderate withdrawal, as well as

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persons experiencing non-acute physical or psychiatric complications associated with their chemical dependence.

Such services are appropriate for persons who are intoxicated by alcohol and/or substances, who are suffering from mild withdrawal, coupled with situational crisis, or who are unable to abstain with an absence of past withdrawal complications.

Units of Service: Patient Days

3059 - Medically Supervised Withdrawal Services – Outpatient

As defined in Part 816 of OASAS' regulations, medically supervised withdrawal services provided in an outpatient setting must be provided under the supervision and direction of a licensed physician, and shall include medical supervision of persons undergoing moderate withdrawal or who are at risk of moderate withdrawal, as well as persons experiencing non-acute physical or psychiatric complications associated with their chemical dependence.

Such services are appropriate for persons who are intoxicated by alcohol and/or substances, who are suffering from mild withdrawal, coupled with situational crisis, or who are unable to abstain with an absence of past withdrawal complications.

Units of Services: Visits

3070 - Shelter Plus Care Housing

A federally funded program of housing assistance specifically targeted to homeless persons with disabilities and their families. For programs administered by OASAS and/or OMH, "persons with disabilities" are "persons who are seriously mentally ill and/or have chronic problems with alcohol, drugs or both". Funds may be used for the payment of rent stipends up to the federally-established Fair Market rent, and associated administrative expenses. OASAS and OMH require any not-for-profit agency in receipt of these funds to report the funds in a separate program column, indexed if necessary on the CBR and CCR. Shelter Plus Care Grants are made for five or ten years at a time. This program code is used in cases where the federal funds flow through OASAS or OMH.

Units of Service: None

3078 - Shelter Plus Care Case Management

Provides placement in permanent supportive housing with support services to homeless single adults and/or families who have completed a substance abuse treatment program or patients in a medically assisted treatment program. Case management services, which include counseling, education and employment assistance, facilitate clients to move toward self sufficiency and independent living.

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Units of Service: None

3100 - Prevention Resource Centers

As training and technical assistance centers, these Prevention Resource Centers (PRCs) will work in partnership with OASAS and OASAS-funded prevention providers to build capacity and resources to help communities facilitate partnerships and collaborations focusing on effective prevention strategies and programs that address alcohol, other drug abuse and problem gambling. PRCs will also serve as a key component in the transfer of knowledge to communities and prevention providers on current prevention science. PRCs can be operated either Regionally or Locally. Regional PRCs will operate in multiple counties/boroughs in a designated OASAS region. Local PRCs will operate within their local county/borough or local communities.

Units of Service: None

3270 - NY NY III: Post-Treatment Housing

Housing opportunities combined with appropriate supportive services that meet the needs of homeless individuals who have completed some course of treatment for a substance abuse disorder and are at risk of street homelessness or sheltered homelessness and who need long-term supportive housing to sustain sobriety and to achieve independent living.

Units of Service: None

3370 - NY NY III: Housing for Persons at Risk for Homelessness

Housing opportunities combined with appropriate supportive services that meet the needs of homeless individuals with a substance abuse disorder that is a primary barrier to independent living and who also have a disabling clinical condition.

Units of Service: None

3470 - Permanent Supported Housing

Housing opportunities combined with appropriate supportive services that meet the needs of individuals who have completed a course of treatment for a substance abuse disorder and are at risk of street homelessness or sheltered homelessness and who need transitional supportive housing to sustain sobriety and achieve independent living. Congregate Housing is a single building for the purposes of providing apartments of a size and character that conforms to applicable state and city laws and regulations. The supportive housing units may be part of a larger building. Scattered Site Housing is apartments for the purposes of housing and serving the tenants who are the recipients of this program.

Units of Service: None

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3500 - Medically Managed Detoxification

As defined in Part 816 of OASAS' regulations, medically managed detoxification services are designed for patients who are acutely ill from alcohol-related and/or substance-related addictions or dependence, including the need for medical management of persons with severe withdrawal or risk of severe withdrawal symptoms, and may include individuals with or at risk of acute physical or psychiatric comorbid condition. Individuals who are incapacitated to a degree which requires emergency admission, may be admitted to such facility in accordance with Section 21.09 or 23.02 of the Mental Hygiene Law. Such services shall not be provided on an ambulatory basis.

Units of Service: Patient Days

3510 - Medically Monitored Withdrawal

As defined in Part 816 of OASAS' regulations, medically monitored withdrawal services can be provided by any provider of services certified by OASAS to provide inpatient or residential chemical dependence services and are designed for persons intoxicated by alcohol and/or substances, or who are suffering from mild withdrawal coupled with situational crisis, or who are unable to abstain with an absence of past withdrawal complications, or who are individuals in danger of relapse. Such services do not require physician direction or direct supervision by a physician, and are designed to provide a safe environment in which a person may complete withdrawal and secure a referral to the next level of care.

Units of Service: Patient Days

3520 - Medically Supervised Outpatient

These programs assist individuals who suffer from chemical abuse or dependence and their family members and/or significant others through group and individual counseling; education about, orientation to, and opportunity for participation in, relevant and available self-help groups; alcohol and substance abuse disease awareness and relapse prevention; HIV and other communicable diseases, education, risk assessment, supportive counseling and referral; and family treatment. In addition, social and health care services, skill development in accessing community services, activity therapies, information and education about nutritional requirements, and vocational and educational evaluation must be available either directly or through written agreements. Procedures are provided according to an individualized assessment and treatment plan. This service mandates that medical staff be part of the multi-disciplinary team and the designation of a Medical Director, which provides for medical oversight and involvement in the provision of outpatient services. These services are Medicaid eligible providing other standards pertaining to fee-for-service Medicaid are met.

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Units of Service: Visits

3528 - Enhanced Medically Supervised Outpatient

3530 - Outpatient Rehabilitation Services

This service level is designed to serve more chronic individuals who have inadequate support systems, and either have substantial deficits in functional skills or have health care needs requiring attention or monitoring by health care staff. These programs provide social and health care services, skill development in accessing community services, activity therapies, information and education about nutritional requirements, and vocational and educational evaluation. Clients initially receive these procedures five days a week for at least four hours per day. There is a richer staff to client ratio for these services compared to other outpatient levels and these services are required to have a half-time staff person qualified in providing recreation and/or occupational services as assistant or registered nurse. Like=half-time nurse practitioner, physician medically supervised outpatient, outpatient rehabilitation services, mandate that medical staff be part of the multi-disciplinary team and the designation of a Medical Director, which provides for medical oversight and involvement in the provision of outpatient services. These services are Medicaid eligible providing other standards pertaining to fee-for-service Medicaid are met.

Units of Service: Visits

3538 - Enhanced Outpatient Rehabilitation Services

3550 - Chemical Dependence Inpatient Rehabilitation Services

An intensive program for clients requiring evaluation and treatment services in a highly structured setting. The length of stay is determined on the basis of client characteristics and usually ranges from 21 to 60 days. The program is medically supported and should also provide chemical dependence education and counseling services for significant others of chemical dependence clients. This type of program is appropriate for clients who need concentrated, therapeutic service prior to community residence, or as their sole form of residential care. Generally, inpatient rehabilitation programs should be freestanding facilities. They may also be operated as special discrete units in a general hospital or hospital for mental illness, organized separately from acute care services.

Units of Service: Patient Days

3551 - Residential Rehabilitation Services for Youth (RRSY)

As defined in Part 817 of OASAS' regulations, residential rehabilitation services for youth is an inpatient treatment program which provides active treatment to adolescents in need of chemical dependence services. Active treatment is provided through a multi-disciplinary team. In an RRSY program, the multi-disciplinary team defined in Part 800 of OASAS'

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regulations is expanded to include (1) a psychiatrist, or a physician and a clinical psychologist and (2) a CSW or an RN or an Occupational Therapist.

Admission to an RRSY is based on a Pre-Admission Certification by an Independent Pre-Admission Certification team.

Units of Service: Patient Days.

3560 - Intensive Residential

These programs assist individuals who suffer from chemical dependence, who are unable to maintain abstinence or participate in treatment without the structure of a 24-hour/day, 7 day/week residential setting and who are not in need of acute hospital or psychiatric care or chemical dependence inpatient services. In addition to counseling, peer group counseling, supportive services, educational services, structured activity and recreation and orientation to community services, intensive residential programs provide the following, either directly or by referral: vocational procedures such as vocational assessment, job skills training and employment readiness training; parenting, personal, social and community living skills training including personal hygiene and leisure activities. These services provide a minimum of 40 hours/week of procedures within a therapeutic milieu.

Units of Service: Patient Days

3570 - Community Residential

These services provide a structural therapeutic milieu while residents are concurrently enrolled in an outpatient chemical dependence service which provides addiction counseling. Community residential services provide the following procedures either directly or by referral: vocational procedures such as vocational assessment, job skills training and employment readiness training; parenting, personal, social and community living skills training including personal hygiene and leisure activities. Individuals appropriate for this level of care include persons who are homeless or whose living environment is not conducive to recovery and maintaining abstinence.

Units of Service: Patient Days

3580 - Supportive Living

A community residence program providing continued congregate living to chronic alcoholic persons with a poor prognosis for independent living. Clients will be referred from halfway houses or recovery homes. The facility will consist of a group home or apartment without regular on-site staffing. This type of setting provides fellowship and peer group support for the maintenance of recovery for clients who do not otherwise have the opportunity to live in an environment supportive of recovery. Length of stay is long term and can be indefinite.

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Units of Service: Patient Days

3810 - Managed Addiction Treatment Services (MATS)

Managed Addiction Treatment Services (MATS) is a program that provides case management services to Medicaid eligible recipients of chemical dependence services. The goal of MATS is to assure effective and appropriate access to needed treatment services and positive treatment outcomes for Medicaid recipients. Services may include linking recipients with appropriate services, case-specific advocacy and monitoring access to and utilization of services to avoid duplicative services. Case management services will be provided by the Local Governmental Unit through a partnership between the local mental hygiene agency and the local department of social services (LDSS).

Units of Service: None

3970 - Recovery Community Centers

Recovery Community Centers utilize peer-to-peer recovery support services to help people initiate and/or sustain recovery from alcohol and drug use disorders as well as provide support to family members of people needing, seeking, or in recovery. The goal of these Community Centers is to help persons in recovery sustain such recovery on a long-term basis. To meet this goal, each Recovery Community Center will provide needed emotional, informational, and social support to persons in recovery, as well as to their families.

Units of Service: None

4030 - Residential Chemical Dependency Program for Youth (Short-Term)

A voluntary intensive inpatient rehabilitation program for youthful clients who require concentrated therapeutic services in a drug-free setting. It provides active treatment through multi-disciplinary clinical services designed to achieve dependence-free discharge to non-residential settings. The program is part of a continuum of care for chemically dependent youth and may be operated by public, private not-for-profit or proprietary sponsors. The planned length of stay is 45 to 60 days.

Units of Service: Patient Days

4045 - Specialized Services Substance Abuse Programs

Specialized chemical dependence services not defined in other regulations that must be provided in accord with the OASAS rules, regulations, and requirements.

Units of Service: To be determined

4060 - Residential Chemically Dependency Program for Youth (Long-Term)

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A voluntary residential recovery home program for youthful clients in a drug-free setting. It provides residential therapeutic care to those youths with a history of chronic chemical dependency. The program is part of a continuum of care for chemically dependent youths and may be operated by public, private not-for-profit or proprietary sponsors. The planned length of stay is more than 60 days but does not exceed 15 months.

Units of Service: Patient Days

4072 - Vocational Rehabilitation

Vocational rehabilitation is a process that prepares people for employment by helping them choose a vocational role and function that is consistent with their abilities, achievements, interests, and functioning capacity. The specific goals of a vocational rehabilitation program vary with the needs of the target population. The process includes the following services: vocational testing, assessment, counseling, pre-vocational activities, training, educational services, life skills/employability referrals, job referrals and placement, and post-placement counseling and follow-up. Programs provide these vocational rehabilitation services directly or by referring the client to an appropriate resource.

Units of Service: None

4074 - Support Services – Educational

Specialized chemical dependence related support services to provide educational services.

Units of Service: None.

4075 - Community Services

Specialized chemical dependence related support services to provide community services by program staff, such as telephone crisis counseling.

Units of Service: None

4077 - Resource

Specialized chemical dependence related support services to provide resource support, such as training.

Units of Service: None

4078 - Program Administration

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Specialized chemical dependence related support services to provide program administration.

Units of Service: None

4778 - Legislative Member Item

Programs that provide chemical dependence projects and services funded by General Fund, Local Assistance Account Member Item appropriations.

Units of Service: None

5550 - Chemical Dependence Prevention Services

Activities designed to decrease risk factors and increase protective factors for substance use and abuse.

Units of Service: None

5990 - Dual Diagnosis Coordinator

Specialized chemical dependence related support services to provide coordination of care for dually diagnosed patients.

Units of Service: None

6030 - Methadone-to-Abstinence – Residential

Methadone treatment delivered in a residential setting in gradually decreasing doses to the point of abstinence, followed by continued drug-free treatment.

Units of Service: Patient Days

6040 - Methadone-to-Abstinence – Day Service

Methadone treatment delivered in a day service setting in gradually decreasing doses to the point of abstinence, followed by continued drug-free treatment.

Units of Service: Visits

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General Office of Mental Health (OMH) Reporting Requirements

OMH service providers are required to report expenses and revenues for each program/site on the core and supplemental schedules of the Consolidated Fiscal Report (CFR). In most cases, program/sites of the same program type are then aggregated on Schedules Department of Mental Hygiene (DMH)-1, DMH-2 and DMH-3. The general program/site and program type reporting requirements are:

- Program/Site reporting on Schedules CFR-1, CFR-4, CFR-4A, OMH-1, OMH-2 and OMH-3.
- Program Type reporting on Schedules DMH-1, DMH-2, and DMH-3.

Exceptions to Program/Site Reporting (on CFR-1, CFR-4, CFR-4A, OMH-1, OMH-2 and OMH-3):

- *OMH Satellites*
A satellite is defined as a physical extension of a program under that program's operating certificate. *Do not report these satellite programs on a site specific basis.* The expenses, revenues, and units of service will be included in the certified program.
- *OMH Start-up*
OMH programs having a start-up component (as approved on their budget) will treat the start-up as a separate program and report revenue and expenses in the column adjacent to the program column that received the start-up funds. For OMH start-ups, enter "A0" as the program code index. Example: 6070 A0. If there are two or more start-ups for a particular program type, enter "A1" for the first occurrence, "A2" for the second occurrence, etc.
- *OMH Programs with multiple sites under the same license*
Licensed programs are reported by program/site as designated under a specific operating certificate (i.e., for Treatment/Apartment programs (program code 7070), all apartments operating under a specific license must be reported together).

Exceptions to Program Type Reporting (on DMH-1, DMH-2 and DMH-3):

- The following programs *must* be reported by program/site throughout the CFR (including the claiming schedules): Permanent Housing Program (program code 1070), Family Based Treatment (program code 2040), Transient Housing (program code 2070), Treatment/Congregate (program code 6070), Support/Congregate (program code 6080), Community Residence, Children & Youth (program code 7050) and Community Residence, Single Room Occupancy (program code 8050), supported SRO (program code 5070).

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- The following OMH licensed programs must be reported by program/site on Schedules CFR-1, CFR-4 and CFR-4A and *can* be reported by program type on Schedules DMH-2 and DMH-3: Treatment/Apartment (program code 7070) and Support/Apartment (program code 7080).

CBR vs. CFR reporting

Programs should only be reported discretely if they are operated as individual programs and are not part of a larger program. Additionally, a program reported discretely on the approved CBR must also be reported discretely on all other fiscal documents submitted to OMH and the Health Department. For example, providers may not report a case management program's expenses and revenues as a discrete program on one document, but include those expenses and revenues as part of a clinic treatment program on a different document. Refer to the next item if a program/site is reported by funding source on the CBR.

When to report program/sites by funding source

OMH program/sites may be split by funding source (i.e., reinvestment versus non-reinvestment funding) *ONLY* on the claiming schedules (DMH-2 and DMH-3) *NOT* on the cost reporting schedules (CFR-1 through CFR-6). Please refer to the software instructions on the creation of additional sites on schedules DMH-2 and DMH-3 to accommodate these multiple occurrences.

When to Index Program Codes

OMH program codes may need to be indexed in certain situations when using software. If a service provider operates more than one program/site of the same program type (i.e., two treatment/ congregate facilities), which are not aggregated by program type on the claiming schedules, the program codes must be indexed.

The program codes are indexed on approved CFR software by the use of a two digit field following the four digit program code.

Example: A service provider operates three treatment/congregate facilities (6070). These program/sites are reported in three separate columns on the core schedules. This program type is not aggregated by program type on the claiming schedules, so these program/sites are also reported in three separate columns on Schedules DMH-1, DMH-2 and DMH-3. The program codes are indexed *throughout the CFR document* as 6070 01, 6070 02, and 6070 03.

There have been a significant number of changes to the OMH listing of Program Codes and Definitions for periods beginning 7/1/10 for NYC; 1/1/10 Upstate and Long Island. The following crosswalk is provided to identify changes you may need to accommodate on your CFR submission.

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Following this alphabetic list is a numeric list of program definitions and the corresponding codes.

Program Type	Program Code	Changes
Adult Home Supportive Case Management (AHSCM)	6820	New Program Code
Adult Home Supportive Case Management Service Dollars	6920	New Program Code
Advocacy/Support Services	1760	
Affirmative Business/Industry	2340	
Assertive Community Treatment (ACT) Program	0800	Revised Definition
Assertive Community Treatment (ACT) Program Service Dollars	8810	Revised Definition
Assisted Competitive Employment	1380	
Blended Case Management (BCM)	0820	Revised Definition
Blended Case Management Service Dollars	0920	New Program Code
Case Management Service Dollars Administration	2810	Revised Name & Definition
Bridger Services	1990	Deleted- Combined into new program "non-Medicaid Care Coordination" (2720)
C&F Clinic Plus Outreach and Screening Services (Unlicensed Program)	0790	
Case Management	0810	Deleted combined into new program "non-Medicaid Care Coordination (2720)
Non-Medicaid Care Coordination	2720	New Program New Program and Definition – formerly 0810 and 1990
Clinic Treatment	2100	
Community Residence, Children & Youth	7050	
Community Residence, Single Room Occupancy (SRO)	8050	
Comprehensive PROS With Clinic	6340	Revised Definition for Units of Service
Comprehensive PROS Without Clinic	7340	Revised Definition for Units of Service
Compulsive Gambling Education, Assessment & Referral Services	2790	
Compulsive Gambling Treatment	2780	
Conference of Mental Hygiene Directors	2860	

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Program Type	Program Code	Changes
Consumer Service Dollars (Non ICM/SCM/ACT)	2820	Deleted, replaced with Flexible Recipient Service Dollars New Program name and code (1230)
Continuing Day Treatment	1310	
Coordinated Children's Services Initiative	2990	
CPEP Crisis Beds	2600	
CPEP Crisis Intervention	3130	
CPEP Crisis Outreach	1680	
CPEP Extended Observation Beds	1920	
Crisis Intervention	2680	
Crisis Residence	0910	
Crisis/Respite Beds	1600	
Day Treatment (Children & Adolescents)	0200	
Drop In Centers	1770	
Enclave in Industry	1340	
Family Based Treatment Program	2040	
Family Care	0040	
Family Support Services (Children & Family)	1650	
FEMA Crisis Counseling Assistance and Training	1690	
Flexible Recipient Service Dollars	1230	New Program Name and Code, formerly consumer service code 2820
Geriatric Demo Gatekeeper	1410	
Geriatric Demo Physical Health-Mental Health Integration	1420	
HCBS Waiver Crisis Response	2260	Deleted, now under HCBS (2300)
HCBS Waiver Family Support	2250	Deleted, now under HCBS (2300)
HCBS Waiver Individualized Care Coordination	2230	Deleted, now under HCBS (2300)
HCBS Waiver Intensive-in-Home	2280	Deleted, now under HCBS (2300)
HCBS Waiver Respite Care	2240	Deleted, now under HCBS (2300)
HCBS Waiver Skill Building	2270	Deleted, now under HCBS (2300)
HCBS Waiver Services (Non-Licensed Program)	2300	New Program Code

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Program Type	Program Code	Changes
Home Based Crisis Intervention	3040	
Homeless Placement Services (Non-Licensed Program)	1960	
Home Based Family Treatment (Non-Licensed Program)	1980	New Program Code
Inpatient Psychiatric Unit of a General Hospital	3010	
Intensive Case Management	1810	Revised Definition Code
Intensive Case Management Service Dollars	1910	New Program Code
Intensive Case Management (ICM) Services Dollars Management	2810	See Case Management Service Dollars Administration
Intensive Case Management/Supportive Case Management/Blended Case Management Emergency and Non-Emergency Service Dollars	2830	Deleted and replaced with 1910,6910,0920, 6920
Intensive Psychiatric Rehabilitation Treatment (IPRT)	2320	
Limited License PROS	8340	Revised Definition for Units of Service
Local Governmental Unit (LGU) Administration	0890	
Local Governmental Unit (LGU) Administration - Reinvestment and Medication Grant Program (MGP) – OMH Only	0860	
MICA Network	5990	
Monitoring and Evaluation, CSS	0870	
Multicultural Initiative	3990	
Non-Medicaid Care Coordination	2720	New Program Code Name and Definition Formerly 0810-1990
Ongoing Integrated Supported Employment Services	4340	
On-Site Rehabilitation	0320	
Outreach	0690	
Partial Hospitalization	2200	
Permanent Housing Program (PHP)	1070	
PROS Rehabilitation and Support Subcontract Services	9340	
Psychosocial Club	0770	
Recovery Center	2750	New Program Code
Recreation	0610	
Residential Treatment Facility – Children & Youth	1080	
Residential Treatment Facility Transition Coordinator – Community	2880	Revised Definition
Respite Services	0650	

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Program Type	Program Code	Changes
RTF/HCBS Service Dollars	2980	New Program Code Formerly Consumer Service Dollars (2820)
School Based Mental Health	1510	Revised Definition
School Program without Clinic	1520	Program Deleted
Shelter Plus Care Housing (when funds flow through OMH, use 2070 when they do not)	3070	Revised Definition
Sheltered Workshop/Satellite Sheltered Workshop	0340	
Single Point of Access (SPOA)	1400	
Special Legislative Grant	1190	
Support Apartment	7080	
Support Congregate	6080	
Supported Education	5340	
Supported Housing Community Services	6060	
Supported Housing Rental Assistance	6050	
Supported Single Room Occupancy (SP-SRO)	5070	
Supportive Case Management (SCM)	6810	Revised Definition
Supportive Case Management Service Dollars	6910	New Program Code
Teaching Family Home	4040	
Transient Housing – THP, some PHP and some S+C (funds not flowing through OMH)	2070	
Transition Management Services	1970	
Transitional Employment Placement (TEP)	0380	
Transportation	0670	
Treatment Apartment	7070	
Treatment Congregate	6070	
Vocational Services (Children & Family)	1320	
Work Program	3340	

0040 - Family Care (Licensed Program)

The Family Care program provides a 24-hour supervised setting, clinical services as needed and case management services to maximize linkages with community support services to persons who no longer require inpatient care, who cannot yet function in an independent living arrangement and who have demonstrated a functional level appropriate for living in a natural family environment.

Units of Service: Count one patient day as one unit.

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0200 - Day Treatment (Licensed Program)

Day treatment services for children and adolescents provide intensive, non-residential services. The programs are characterized by a blend of mental health and education services provided in a fully integrated program. Typically, these programs include education in small classes with an emphasis on individualized instruction, individual and group counseling, family services such as family counseling, crisis intervention, interpersonal skill development and behavior modification. Children and adolescents receiving day treatment services live at home or in the community but are identified by their school district as seriously emotionally disturbed and cannot be maintained in regular classrooms.

Units of Service:

- Brief Day Treatment: One to three hours.
- Half-day visit: Three but less than five hours.
- Full day visit: Five hours or over.
- Collateral visit: At least 30 minutes.
- Home visit: At least 30 minutes.
- Crisis-visit: At least 30 minutes.
- Pre-Admission full-day visit: At least five hours.
- Pre-Admission half day visit: At least three hours but less than five hours.

Total Units of Service: Add weighted visits by category to calculate a total.

0320 - On-site Rehabilitation (Non-Licensed Program)

The objective is to assist individuals disabled by mental illness who live in adult congregate care settings, supervised or supported living arrangements to achieve their treatment and community living rehabilitation goals. Services include one or a combination of: (1) consumer self-help and support interventions; (2) community living; (3) academic and/or social leisure time rehabilitation training and support services. These services are typically provided either at the residential location of the resident or in the natural or provider-operated community settings which are integral to the life of the residents. These on-site rehabilitation services are provided by a team that is either located at the residential site or which functions as a mobile rehabilitation team traveling from site to site.

Units of Service:

- Brief Day Visit: less than 3 hours.
- Half-day visit: 3 but less than 5 hours.
- Full-day visit: 5 hours or more.

Total Units of Service: Add weighted visits by category to calculate a total.

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0340 - Sheltered Workshop/Satellite Sheltered Workshop (Non-Licensed Program)

The objective is to provide vocational assessment, training, and paid work in a protective and non-integrated work environment for individuals disabled by mental illness. Services are provided according to wage and hour requirements specified in the Fair Labor Standards Act administered by the Department of Labor.

Units of Service:

- Brief day visit: Less than 3 hours
- Half-day visit: 3 but less than 5 hours
- Full-day visit: 5 hours or more

Total Units of Service: Add weighted visits by category to calculate a total.

0380 - Transitional Employment Placement (TEP) (Non-Licensed Program)

The objective is to strengthen the individual's work record and work skills toward the goal of achieving assisted or unassisted competitive employment at or above the minimum wage paid by the competitive sector employer. TEP's provide time-limited employment and on-the-job training in one or more integrated employment settings as an integral part of the individual's vocational rehabilitation growth.

- Direct staff hours: The number of staff hours spent by staff in providing case management services face-to-face or by telephone directly to Consumers or collaterals.
- Indirect staff hours: The number of staff hours spent by staff in providing case management services on behalf of Consumers other than face-to-face or by telephone directly with Consumers or collaterals.

Units of Service: Count the total number of staff hours (combine direct and indirect).

0610 – Recreation (Non-Licensed Program)

A program of social, recreational, and leisure activities that are intellectually and interpersonally stimulating but which are not necessarily part of a goal-based program plan. Agencies which provide no other types of programs should report this service in the recreation category. Recreation activities which are part of other programs should not be reported as part of recreation programs.

Units of Service: Total the number of visits.

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0650 – Respite Services (Non-Licensed Program)

Temporary services (not beds) provided by trained staff in the consumer's place of residence or other temporary housing arrangement. Includes custodial care for a disabled person in order that primary care givers (family or legal guardian) may have relief from care responsibilities. The purpose of respite services is to provide relief to the primary care provider, allow situations to stabilize and prevent hospitalizations and/or longer term placements out of the home. Maximum Respite Care services per consumer per year are 14 days.

Units of Service: Total the staff hours spent providing respite services.

0670 – Transportation (Non-Licensed Program)

The provision of transportation to and from facilities or resources specified in the consumer's individual treatment plan as a necessary part of his/her service for mental disability. This includes all necessary supportive services for full and effective integration of the consumer into community life.

- A consumer trip is the one-way transportation of a consumer from one place to another. For example, transportation of one consumer from home to the facility and back is counted as two trips; transportation of two consumers to and from is counted as four trips.

Units of Service: Count the number of trips.

0690 – Outreach (Non-Licensed Program)

Outreach programs/services are intended to engage and/or assess individuals potentially in need of mental health services. Outreach programs/services are not crisis services. Examples of applicable services are socialization, recreation, light meals, and provision of information about mental health and social services. Another type of service within this program code includes off-site, community based assessment and screening services. These services can be provided at forensic sites, a consumer's home, other residential settings, including homeless shelters, and the streets.

This program code should **not** be used for services that are provided by a licensed outpatient program. For unlicensed crisis type services use program code 2680 Crisis Intervention.

Units of Service: Total the number of contacts.

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**0770 - Psychosocial Club
(Non-Licensed Program)**

The objective is to assist individuals disabled by mental illness to develop or reestablish a sense of self-esteem and group affiliation, and to promote their recovery from mental illness and their reintegration into a meaningful role in community life through the provision of two or more of the following: (1) consumer self-help and empowerment interventions; (2) community living: (3) academic; (4) vocational and/or (5) social-leisure time rehabilitation, training and support services.

Units of Service: Count each consumer visit as one unit (no more than one unit of service per consumer per day unless the consumer returns for a planned evening program in which case count as two (2) units).

**0790 – C&F Clinic Plus Outreach and Screening Services
(Unlicensed Program)**

C&F Clinic Plus Outreach and Screening Services are conducted by designated Child and Family Clinic Plus clinics. Mental Health screening under Clinic Plus is a broad based approach to identify children and adolescents with emotional disturbances, and intervene at the earliest possible opportunity. Screenings are provided in community settings, and with the prior written consent of the child's parent or legal guardian.

This code can only be used by providers who have been designated as a Child and Family Clinic Plus provider, and who operate a licensed Clinic Treatment program serving children.

Units of Service: Count each Contact as a unit of service.

**0800 Assertive Community Treatment (ACT)
(Licensed Program)**

The Assertive Community Treatment Team (ACT) provides mobile intensive treatment and support to individuals who are diagnosed with severe mental illness and have been unsuccessful in traditional forms of treatment. The focus is on the improvement of an individual's quality of life in the community and reducing the need for inpatient care, by providing intense community-based treatment services by an interdisciplinary team of mental health professionals.

ACT Teams will be instituted in accordance with two operational models of 68 or 48 consumers.

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Units of Service: Intensive Full Program – 6 or more face-to-face contacts per individual per month and may include three collateral visits count as one unit. Intensive Partial Payment represents between 2 and 5 face-to-face contacts per individual per month and count as one unit. Supportive Program – 2 or more face-to-face contacts per individual per month count as one unit. Total Units of Service: Total the number of contacts.

**0810 - Case Management
(Non-Licensed Program) See Non-Medicaid Care Coordination (2720)**

0820 Blended Case Management (BCM); (Non-Licensed Program)

In addition to the Targeted Case Management program description, BCM facilitates a team approach to case management services by combining the caseloads of multiple Intensive Case Managers (ICMs) and/or Supportive Case Managers (SCMs). A blended team can be composed of any of the following ratios of ICM and SCM:

- 1 ICM and 1 SCM
- 2 ICM and 1 SCM
- 1 ICM and 2 SCM
- Any multiples of the above

Team caseload size and minimum number of aggregate monthly contacts required for Medicaid billing is determined by the mix of ICMs and SCMs on the team. For ICM programs serving Children and Families, 25% of aggregate contacts provided by ICM clients may be collateral. SCM collaterals are not billable.

Total Units of Service: Count the number of contacts.

**0860 - Local Governmental Unit (LGU) Administration - Reinvestment and Medication Grant Program (MGP)
(Non-Licensed Program)**

This program category includes all local government costs related to administering mental hygiene services that are provided by a local government or by voluntary agency pursuant to a contract with a local governmental unit. This program category can also be used for services funded under the Community Reinvestment Act (RIV) and for Kendra's Medication Grant Program. This program can only be used with fund source codes 170D, 200, 300 and 400. Agency administrative costs allocated to the operating costs of this program via the Ratio Value allocation methodology are redistributed to other OMH programs in the CFR.

Units of Service: Not applicable.

**0870 - Monitoring and Evaluation (CSS)
(Non-Licensed Program)**

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Funds provided for monitoring and evaluation activities associated with the program and fiscal management of the CSS program provided by a Core Service Agency and those costs incurred by the Local Government Unit for the Administration of the CSS program in those counties which have opted to administer the combined CSS/620 funding streams. Agency administrative costs allocated to the operating costs of this program via the Ratio Value allocation methodology are redistributed to other OMH programs in the CFR.

Units of Service: Not applicable.

**0890 - Local Governmental Unit (LGU) Administration
(Non-Licensed Program)**

The Local Governmental Unit is defined in Article 41 of the Mental Hygiene Law. This program category includes all local government costs related to administering mental hygiene services that are provided by a local government or by voluntary agency pursuant to a contract with a local governmental unit. This program does not include agency administration and can only be used with fund source code 001A.

Units of Service: Not applicable.

**0910 – Crisis Residence
(Licensed Program)**

A licensed residential (24 hours/day) stabilization program, which provides services for acute symptom reduction and the restoration of patients to pre-crisis level of functioning. These programs are time limited for persons until they achieve stabilization (generally up to 30 days). Crisis residences serve persons experiencing rapid or sudden deterioration of social and personal conditions such that they are clinically at risk of hospitalization but may be treated in this alternative setting.

This program is licensed for adults as defined in 14NYCRR589 and for children and adolescents as defined in 14NYCRR594.

Units of Service: One resident day.

0920 Blended Case Management Service Dollars; (Non-Licensed)

All Blended Case Management (BCM) programs have access to “service dollars.” All service dollar programs are for emergency and non-emergency purposes and are to be used as payment of last resort. The purpose of the service dollar is to provide funds for recipients’ immediate and/or emergency needs. The use of service dollars in any of these programs should include participation of the recipient of services, who should play a significant role in the planning for, and the utilization of, service dollars. Also, as the needs of the recipient change,

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the money can be redirected to purchase the type of service that is currently needed. Services purchased on behalf of a recipient, such as Respite or Crisis Services, should be reported using the appropriate Service Dollar program code.

Units of Service: Count the number of recipients utilizing these funds.

**1070 - Permanent Housing Program (PHP)
(Non-Licensed Program)**

A federally-funded program of housing assistance specifically targeted to the homeless mentally ill. Funds may be used for: the acquisition and/or rehabilitation of a program site; operating expenses; support services; and administrative expenses. These funds flow to OMH from the federal Department of Housing and Urban Development. OMH will then advance these funds to the not-for-profit provider agency via the existing general fund contract. OMH requires that any not-for-profit agency in receipt of these funds must report the funds in a separate program column with programs indexed if necessary. New Permanent Housing Grants are made for five years at a time. The term for renewal grants varies from one to three years. In cases where the funds go directly to the provider and do not flow through OMH (after federal year 1992), see program code 2070).

Units of Service: Not applicable.

**1080 - Residential Treatment Facility - Children and Youth
(Licensed Program)**

Residential Treatment Facilities (RTF's) provide fully-integrated mental health treatment services to seriously emotionally disturbed children and youth between the ages of five and 21 years of age. These services are provided in 14-61 bed facilities which are certified by both the Office of Mental Health (OMH) and the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) or Council on Accreditation (COA). RTF's are less intensively staffed than inpatient units, but provide a much higher level of services and staffing than community residences, Office of Children and Family Services (formerly the Department of Social Services) group homes, and/or child care institutions.

Units of Service: Count one patient day as one unit.

**1190 - Special Legislative Grants
(Non-Licensed Program)**

Specific grants funded as a result of legislative member support, targeted for a particular purpose.

Units of Service: Not applicable.

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1230 Flexible Recipient Service Dollars (Non-Medicaid Programs); (Non-Licensed Program)

Flexible Recipient Service Dollars are not based on a particular fiscal model and are available to provide for a recipient's emergency and non-emergency needs. These funds are to be used as payment of last resort. The use of the service dollars should include participation of the recipient of services, who should play a significant role in the planning for, and the utilization of, service dollars. Services purchased on behalf of a recipient, such as Respite or Crisis Services, should be reported using this Service Dollar program code. Examples of services may include housing, food, clothing, utilities, transportation, and assistance in educational, vocational, social or recreational and fitness activities, security deposits, respite, medical care, crisis specialist, homemakers and escorts. This program code cannot be allocated for AHSCM, ICM, SCM, BCM, ACT, RTF Transition Coordinators or Home and Community Based Waiver Services. Agency administrative expenses cannot be allocated to this program code.

Units of Service: Count the number of recipients utilizing these funds.

1310 - Continuing Day Treatment (Licensed Program)

A continuing day treatment program shall provide active treatment and rehabilitation designed to maintain or enhance current levels of functioning and skills, to maintain community living and to develop self-awareness and self-esteem through the exploration and development of patient strengths and interests. A continuing day treatment program shall provide the following services: assessment and treatment planning, discharge planning, medication therapy, medication education, case management, health screening and referral, psychiatric rehabilitation readiness development, psychiatric rehabilitation readiness determination and referral and symptom management. The following additional services may also be provided: supportive skills training, activity therapy, verbal therapy, crisis intervention services and clinical support services.

Units of Service:

- Regular: shall be at least one hour and up to five hours
- Collateral: shall be at least 30 minutes but not more than 120 minutes.
- Group Collateral: shall be at least one hour and up to two hours.

Count the total number of service hours.

Note: Beginning with the reporting period starting 01/01/09, the measurement of Units of Service will change to Half Day or Full Day. The calculation will match the method for Medicaid Billing.

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1320 - Vocational Services Children and Family (Non-Licensed Program)

The Vocational Program for Adolescents was designed to provide work training and clinical support services for those older adolescents with poor academic performance and social adjustment in regular day treatment programs. The program identifies 5 goals on which to focus:

- Goal 1: Help youths identify problem areas and learn ongoing coping skills (i.e., involvement in support groups, recognizing need for relaxation and medication management);
- Goal 2: Provide Vocational Assessment and on-the-job training and experience;
- Goal 3: Improve Social Skills;
- Goal 4: Improve Educational Functions;
- Goal 5: Provide Family Education and Support.

Units of Service: Count the number of daily staff visits.

1340 - Enclave in Industry (Non-Licensed Program)

The objective is to provide vocational assessment, training, and transitional or long term paid work for individuals with severe disabilities in an integrated employment environment. An enclave consists of a small group of approximately five to eight individuals who work in an industrial or other economic enterprise either as individuals or as a crew. Individuals in enclaves are provided with training, supervision and ongoing support by a job coach/supervisor assigned to the work site by the rehabilitation service agency.

- Direct staff hours: The number of staff hours spent by staff in providing case management services face-to-face or by telephone directly to consumers or collaterals.
- Indirect staff hours: The number of staff hours spent by staff in providing case management services on behalf of consumers other than face-to-face or by telephone directly with consumers or collaterals.

Units of Service: Count the total number of staff hours (combine direct and indirect).

1380 - Assisted Competitive Employment (ACE) (Non-Licensed Program)

The objective is to assist individuals in choosing, finding, and maintaining satisfying jobs in the competitive employment market at minimum wage or higher. When appropriate, ACE provides these individuals with job related skills training as well as long-term supervision and support services, both at the work site and off-site.

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- Direct staff hours: The number of staff hours spent by staff in providing case management services face-to-face or by telephone directly to consumers or collaterals.
- Indirect staff hours: The number of staff hours spent by staff in providing case management services on behalf of consumers other than face-to-face or by telephone directly with consumers or collaterals.

Units of Service: Count the total number of staff hours (combine direct and indirect).

**1400 Single Point Of Access (SPOA)
(Non-Licensed Program)**

A SPOA is a process, *led by a SPOA Coordinator*, that helps Local Governmental Units achieve community based mental health systems that are cohesive and well coordinated in order to serve those individuals most in need of services. There are three types of SPOAs - Children's, Adult Case Management and Adult Housing. The SPOA process provides for the identification of individuals most in need of services, and manages service access and utilization.

This program code should not be used for services that are provided by a licensed out-patient program.

Units of Service: Not applicable.

**1410 – Geriatric Demo Gatekeeper
(Non-Licensed Program)**

The Gatekeeper Program is designed to proactively identify at-risk older adults in the community who are not connected to the service delivery system. Gatekeepers are non-traditional referral sources who come into contact with older adults through their everyday work activities. They are specifically trained to look for signs and symptoms that may indicate the older adults before a crisis occurs. Upon identification of an older adult in need, a trained Gatekeeper makes a phone call to trained staff which initiates the individual's assessment and a variety of in-home supportive services. The program is designed to keep at-risk seniors in their own homes, and prevent premature out-of-home placement. This program code should not be used for services provided by a licensed outpatient program, or for services provided by another active OMH funded program.

Units of Service: Count the total number of contacts.

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**1420 – Geriatric Demo Physical Health-Mental Health Integration
(Non-Licensed Program)**

The Physical Health-Mental Health Integration Program is designed to increase coordination and collaboration between and among physical health and mental health providers. The two integrated care models to be used in this demonstration are 1) the co-location of mental health specialists within primary care settings and 2) improved collaboration between separate providers. Older adults benefit from the increased convenience and coordination of mental and medical disorders. This program code should not be used for services provided by a licensed outpatient program, or for services provided by another active OMH funded program.

Units of Service: Visits

**1510 - School Program Co-located with Clinic Treatment Program
(Non-Licensed Program if reported under this code)**

School based mental health programs provide mental health services in schools to children and adolescents with emotional and/or behavioral issues. The program works in collaboration with the school to facilitate the provision of mental health services within the school environment. This program cannot be used to report expenses or revenues associated with services provided by the licensed Clinic Treatment Program (2100).

Units of Service: Total the number of staff hours.

**1520 - School Program without Clinic
(Non-Licensed Program)**

The OMH Division of Children & Families indicates there are no longer any school mental health programs that are not co-located with clinic. Clinics either have a satellite located in the school, or an affiliation agreement with the school. Therefore, the School Program without Clinic has outlived its purpose and is no longer needed.

Units of Service: N/A

**1600 – Crisis/Respite Beds
(Non-Licensed Program)**

A non-licensed residential program, or dedicated beds in a licensed program, which provide consumers a homelike environment with room, board and supervision in cases where individuals must be removed temporarily from their usual residence.

Units of Service: One resident day.

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**1650 - Family Support Services (Children and Family)
(Non-Licensed Program)**

Family support programs provide an array of formal and informal services to support and empower families with children and adolescents having serious emotional disturbances. The goal of family support is to reduce family stress and enhance each family's ability to care for their child. To do this, family support programs operate on the principles of individualized care and recognizing every child and family is unique in their strengths and needs. Connecting family members to other families with children with serious emotional problems helps families to feel less isolated and identify their own strengths.

Family support programs ideally provide the following four core services: family/peer support, respite, advocacy, and skill building/educational opportunities.

Units of Service: Count the number of paid staff hours.

**1680 – CPEP Crisis Outreach
(Non-Licensed Program - Associated with a Licensed CPEP Program)**

A mobile crisis intervention component of the CPEP offering crisis outreach and interim crisis service visits to individuals outside an emergency room setting, in the community in natural (e.g. homes), structured (e.g., residential programs), or controlled (e.g., instructional) environments. Crisis outreach service visits are emergency mental health services provided outside an emergency room which include clinical assessment and crisis intervention treatment. Interim crisis service visits are mental health services provided to individuals who are released from a CPEP for the purpose of facilitating the individual's community tenure while waiting for the first post-CPEP visit with a community-based mental health provider.

CPEP crisis outreach and interim crisis service visits are Medicaid reimbursable.

This program is one of four program components which, when provided together, form the OMH licensed Comprehensive Psychiatric Emergency Program (CPEP). The other program components of the CPEP are: CPEP Crisis Intervention (3130), CPEP Extended Observation Beds (1920) and CPEP Crisis Beds (2600).

Units of Service:

- Crisis Outreach Visit
- Interim Crisis Visit.
- Count the total number of visits.

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**1690 – FEMA Crisis Counseling Assistance and Training
(Non-Licensed Program)**

A program to provide individual and/or group treatment procedures which are designed to alleviate the mental and emotional crises and their subsequent psychological and behavioral conditions resulting from major disaster or its aftermath. Funded through Federal Emergency Management Agency (FEMA). Agency administrative costs allocated to the operating costs of this program via the Ratio Value allocation methodology are redistributed to other OMH programs in the CFR.

Units of Service: Not applicable

**1760 – Advocacy/Support Services
(Non-Licensed Program)**

Advocacy/support services may be individual advocacy or systems advocacy (or a combination of both). Examples are warm lines, hot lines, teaching daily living skills, providing representative payee services, and training in any aspect of mental health services.

Individual advocacy assists consumers in protecting and promoting their rights, resolving complaints and grievances, and accessing services and supports of their choice.

Systems advocacy represent the concerns of a class of consumers by identifying patterns of problems and complaints and working with program or system administrators to resolve or eliminate these problems on a systemic, rather than individual basis.

Units of Service: Count the total number of contacts.

**1770 - Drop-In Center
(Non-Licensed Program)**

The objective of a Drop-In Center program is to identify and engage persons who may choose not to participate in more structured programs or who might not otherwise avail themselves of mental health services, and to provide services and supports in a manner which these individuals would accept. These programs are low demand, flexible and relatively unstructured, and responsive to individual need and circumstance.

Units of Service: Count the total number of units. Count each consumer visit as one unit (no more than one unit of service per consumer, per day, unless the consumer returns for a planned evening program, in which case, count as two (2) units).

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1810 - Intensive Case Management (ICM); (Non-Licensed Program)

In addition to the general Targeted Case Management program description located in the Spending Plan Guidelines, ICM is set at a case management/client ratio of 1:12. The Traditional ICM model requires a minimum of four (4) 15 minute face-to-face contacts for individual, per month. For programs serving Children and Families, one contact may be collateral. The flexible ICM model requires a minimum of two (2) 15 minute minimum face-to-face contacts per individual, per month, but must maintain a minimum aggregate of 4 face-to-face contacts over the entire caseload. For programs serving Children and Families, 25% of the aggregate contacts can be collaterals.

Units of Service: Count the number of contacts.

The Flexible ICM model requires a minimum of two (2) 15 minute minimum face-to-face contacts per individual, per month but must maintain a minimum aggregate of 4 face-to-face contacts over the entire caseload and 25% of the aggregate contacts may be collateral, count as one unit.

1910 ICM Service Dollars; (Non-Licensed)

All Intensive Case Management (ICM) programs have access to “service dollars.” All service dollar programs are for emergency and non-emergency purposes and are to be used as payment of last resort. The purpose of the service dollar is to provide funds for recipients’ immediate and/or emergency needs. The use of service dollars in any of these programs should include participation of the recipient of services, who should play a significant role in the planning for, and the utilization of, service dollars. Also, as the needs of the recipient change, the money can be redirected to purchase the type of service that is currently needed. Services purchased on behalf of a recipient, such as Respite or Crisis Services, should be reported using the appropriate Service Dollar program code.

Units of Service: Count the number of recipients utilizing these funds.

1920 – CPEP Extended Observation Beds (Non-Licensed Program - Associated with a Licensed CPEP Program)

Beds operated by the Comprehensive Psychiatric Emergency Program which are usually located in or adjacent to the CPEP emergency room, are available 24 hours per day, seven days per week to provide extended assessment and evaluation as well as a safe and comfortable environment for up to 72 hours for persons, who in the opinion of the examining physicians, require extensive evaluation, assessment, or stabilization of their acute psychiatric symptoms. Extended observation bed services are reimbursed at the inpatient psychiatric rate of the hospital where the CPEP is located.

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This program is one of four program components which, when provided together, form the OMH licensed Comprehensive Psychiatric Emergency Program (CPEP). The other program components of the CPEP are: CPEP Crisis Intervention (3130), CPEP Crisis Outreach (1680) and CPEP Crisis Beds (2600).

Units of Service: One (psychiatric) inpatient day.

**1960 – Homeless Placement Services
(Non-Licensed Program)**

Homeless placement services are intended to serve street homeless individuals who, upon assessment and evaluation, have an Axis I mental health diagnosis. The objective of homeless placement services is to identify, engage, assess and provide treatment and housing placement services in order to promote recovery and reintegration into meaningful community life through the provision of the following continuum of services: psychiatric and medical assessment/evaluation, assistance with entitlement benefit applications, as appropriate, mental health and substance abuse treatment services, transitional housing placement and/or permanent supportive housing placement.

Units of Service:

Cluster 1

- a. Completion of Psycho Social summary
- b. Completion of Psychiatric Evaluation
- c. PPD Test Performed

For each item completed for each individual – Count as One Unit of Service

Cluster 2:

- d. Completion of Public Assistance and/or SSI Application
- e. Completion of (Medicaid) Application

For each item completed for each individual – Count as Two Units of Service

Cluster 3:

- a. Enrollment in Mental Hygiene Services

For each enrollment for each individual – Count as Three Units of Service

Cluster 4:

- a. Placement in Transitional Housing

For each individual placed in Transitional Housing – Count as Five Units of Service

Cluster 5:

- a. Placement in Permanent Supportive Housing

For each individual placed in Permanent Supportive Housing – Count as Ten Units of Service

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**1970 – Transition Management (TM) Services
(Non-Licensed Program)**

Transition Management Services (discharge planning) programs provide support for improved community service linkages and timely filing of Medicaid applications for seriously and persistently mentally ill (SPMI) consumers being released from local correctional facilities. The TM focus will be in obtaining post-release services for these consumers. TM can only be used with funding source code 170B.

Units of Service: The number of staff hours.

**1980 – Home Based Family Treatment (Support)
(Non-Licensed Program)**

Under contract and monitoring by the local government unit, this program provides community based mental health family treatment and support to children and adolescents (ages 5 through 18) and their families or caregivers. Services are provided in natural settings such as home schools and community centers. A team approach is taken and the service array includes evaluation/assessment, short term treatment and support using evidence based practice models such as Functional Family therapy and Multisystemic Therapy. Additional services include referral and linkage to appropriate follow-up services as needed. Service visits attributed to this program code are only those separate and distinct from those provided and billed through the agency's clinic license.

Units of Service: Count the number of daily visits.

**1990 – Bridger Services
(Non-Licensed Program) See Non-Medicaid Care Coordination (2720)**

**2040 - Family Based Treatment Program
(Licensed Program)**

The Family Based Treatment Program (FBTP) treats children and adolescents who are seriously emotionally disturbed within a home environment that is caring, nurturing and therapeutic. The program employs professional parents who are extensively trained and supervised. Parents function within a well-structured system that provides respite and other types of support; additionally, they are well paid in recognition of the high levels of responsibility and expectations placed on them by the model. Under the current FBTP initiative, a single provider agency contracts with OMH to provide up to 40 homes. Each home is headed by professional parents. One family specialist is provided for each for each five professional parent couples and a respite couple to provide training, support, advocacy and supervision. The grouping of one respite couple and five professional families with one professional staff person

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forms the "cluster" which is the primary arena for providing professional parent supports, sharing child care data and experiences, and training.

Children served in the FBT Program are between the ages of five and 18, with the target population under 12 years of age. The children exhibit a variety of serious emotional problems.

Children are referred directly to the program by a variety of sources that include psychiatric inpatient programs, Residential Treatment Facilities (RTF's), community agencies and parents.

This is a type of Licensed Housing/Community Residential program for children and adolescents as defined in 14NYCRR594.

Units of Service: Count one resident day as one unit.

**2070 - Transient Housing (THP, Some PHP and some S+C)
(Non-Licensed Program)**

Housing and Urban Development (HUD) funds - Several federally funded programs contribute housing assistance specifically targeted to the homeless mentally ill. When funds do not flow through OMH, but are sent directly to the provider, the funds are reported under this program code and funding code 090 (non-funded) on the DMH-3. Federal Programs which fall into this category are Transitional Housing Program (THP), Supported Housing Demonstration Program (SHDP), and some Shelter Plus Care grants. Funds may be used for: the acquisition and/or rehabilitation of a program site; operating expenses; support services; and administrative expenses. These funds flow directly to the not-for-profit provider agencies from the federal Department of Housing and Urban Development. Nonetheless, OMH requires that any not-for-profit agency in receipt of these funds report the funds in a separate program column with the program code indexed if necessary. These grants are made for five years at a time.

Units of Service: Not applicable.

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2100 - Clinic Treatment (Licensed Program)

A clinic treatment program shall provide treatment designed to reduce symptoms, to improve patient functioning and to provide ongoing support.

A clinic treatment program for adults shall provide the following services: assessment and treatment planning, health screening and referral, discharge planning, verbal therapy, medication therapy, medication education, symptom management and psychiatric rehabilitation readiness determination. The following additional services may also be provided: case management, crisis intervention services, clinical support services and family treatment services.

A clinic treatment program for children shall provide the following services: assessment and treatment planning, verbal therapy, symptom management, health screening and referral, medication therapy, medication education, clinical support services and discharge planning. The following additional services may also be provided: case management, crisis intervention services and family treatment services.

- Brief visit: Shall be reimbursed for services of at least 15 minutes in duration but not more than 29 minutes of face-to-face interaction between one consumer and one therapist
- Regular visit: Shall be reimbursed for services of at least 30 minutes in duration of face-to-face interaction between one consumer and one therapist
- Crisis visit: Shall be reimbursed for services of at least 30 minutes in duration of face-to-face interaction between one consumer and one therapist
- Group therapy visits: Shall be reimbursed for services of at least 60 minutes duration provided to from 2 to 12 consumers and a therapist(s)
- Collateral visit: Shall be reimbursed for:
 - Clinical support services of at least 30 minutes in duration of face-to-face interaction between one or more collaterals and one therapist with or without a consumer; or
 - Family treatment services of at least 30 minutes in duration of face-to-face interaction among all of the following: a consumer, one or more family members, and a therapist.

Group collateral visit: shall be reimbursed for:

- Clinical support services, as defined in Section 587.4(c) (5), of at least 60 minutes in duration but not more than 2 hours and shall represent services to more than one consumer and/or his or her collaterals. Such visits need not include consumers but shall not include more than 12 collaterals and/or consumers in a face-to-face interaction with a therapist for which reimbursement is claimed. Such limitation does

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not preclude the non-reimbursed participation of additional persons in the group session but such participation shall not be separately reimbursed; or

- Family treatment services of at least 60 minutes in duration but not more than 2 hours and shall include services to more than one consumer. For each consumer participant, at least one family member shall participate. However, only one group collateral bill per consumer is allowed per day. Such visits shall not include more than 12 participants, including consumers and family members, for which reimbursement is claimed. Such limitation does not preclude the non-reimbursed participation of additional persons in the group session.
- Family visit: Shall be reimbursed for family treatment services, as defined in Section 587.4(c)(8), of at least 60 minutes in duration of face-to-face interaction between one consumer, one or more of his or her family members, and one therapist. For purposes of billing family visits which meet these criteria, providers shall bill one regular visit and one collateral visit.

Total Units of Service: Add weighted visits by category to calculate a total.

2200 - Partial Hospitalization (Licensed Program)

A partial hospitalization program shall provide active treatment designed to stabilize and ameliorate acute symptoms, to serve as an alternative to inpatient hospitalization, or to reduce the length of a hospital stay within a medically supervised program. A partial hospitalization program shall provide the following services: assessment and treatment planning, health screening and referral, symptom management, medication therapy, medication education, verbal therapy, case management, psychiatric rehabilitation readiness determination and referral, crisis intervention services, activity therapy, discharge planning and clinical support services.

Units of Service:

- Regular: shall be at least four hours and not more than seven hours;
- Collateral: shall be at least 30 minutes and not more than 120 minutes;
- Group Collateral: shall be at least one hour but may be up to two hours in duration.
- Crisis: shall be at least one hour but up to seven hours. In addition, pre-admission visits of at least one hour but up to three hours are allowable. These visits will be counted as crisis visits.

Total Units of Service: Add total service hours to calculate a total.

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**2230 – HCBS Waiver Individualized Care Coordination
(Non-Licensed Program)**

Program code has been deleted

Units of Service: N/A

**2240 – HCBS Waiver Respite Care
(Non-Licensed Program)**

Program code has been deleted.

Units of Service: N/A

**2250 – HCBS Waiver Family Support
(Non-Licensed Program)**

Program code has been deleted.

Units of Service: N/A

**2260 – HCBS Waiver Crisis Response
(Non-Licensed Program)**

Program code has been deleted.

Units of Service: N/A

**2270 – HCBS Waiver Skill Building
(Non-Licensed Program)**

Program code has been deleted.

Units of Service: N/A

**2280 – HCBS Waiver Intensive-in-Home
(Non-Licensed Program)**

Program code has been deleted.

Units of Service: N/A

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**2300 – HCBS Waiver Services
(Non-Licensed Program)**

The purpose of the Home and Community Based Services (HCBS) Waiver, authorized in Section 1915(c) of the Social Security Act, is to maintain children with serious emotional disturbance in their homes and communities who would otherwise be in hospital levels of care by reimbursing for non-traditional services. In addition to Individualized Care Coordination, non-traditional services include: Crisis Response, Intensive In-Home, Respite Care, Family Support Services, and Skill Building. This program waives parental deeming (where parental income and resource are disregarded in the Medicaid application for the child). Services are provided to eligible children between the ages of 5 and 21 years and their families.

Units of Service: Total enrollee months, i.e. the 12 month total of each monthly census number (in months and half months) rounded to the next whole month.

**2320 - Intensive Psychiatric Rehabilitation Treatment (IPRT)
(Licensed Program)**

An intensive psychiatric rehabilitation treatment program is time-limited, with active psychiatric rehabilitation designed to assist a patient in forming and achieving mutually agreed upon goals in living, learning, working and social environments; to intervene with psychiatric rehabilitation technologies, to overcome functional disabilities and to improve environmental supports. An intensive psychiatric rehabilitation treatment program shall provide the following services: psychiatric rehabilitation readiness determination, psychiatric rehabilitation goal setting, psychiatric rehabilitation functional and resource assessment, psychiatric rehabilitation service planning, psychiatric rehabilitation skills and resource development and discharge planning.

Units of Service: Total service hours.

**2340 - Affirmative Business/Industry
(Non-Licensed Program)**

The objective is to provide vocational assessment, training, transitional or long-term paid employment, and support services for persons disabled by mental illness in a less restrictive/more integrated employment setting than sheltered workshops. Affirmative Business programs may include mobile contract services, small retail or wholesale outlets, and manufacturing and service oriented businesses.

Units of Service: Count the total number of consumer hours.

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**2600 – CPEP Crisis Beds
(Non-Licensed Program)**

A residential (24 hour/day) stabilization component of the CPEP, which provides supportive services for acute symptom reduction and the restoration of patients to pre-crisis level of functioning. These programs are time limited (up to five days) for patients until they achieve stabilization. Crisis beds serve persons experiencing rapid or sudden deterioration of social and personal conditions such that they are clinically at risk of hospitalization but may be treated in this alternative setting. CPEP crisis bed services are *neither* funded by OMH *nor* Medicaid-reimbursable, but are purchased from the facility operating these beds.

This program is one of four program components which, when provided together, form the OMH licensed Comprehensive Psychiatric Emergency Program (CPEP). The other program components of the CPEP are: CPEP Crisis Intervention (3130), CPEP Crisis Outreach (1680) and CPEP Extended Observation Beds (1920).

Units of Service: One resident day.

**2680 Crisis Intervention
(Non-Licensed Program)**

Crisis intervention services, applicable to adults, children and adolescents, are intended to reduce acute symptoms and restore individuals to pre-crisis levels of functioning. Examples of where these services may be provided include emergency rooms and residential settings. Provision of services may also be provided by a mobile treatment team, generally at a consumer's residence or other natural setting (not at an in-patient or outpatient treatment setting). Examples of services are screening, assessment, stabilization, triage, and/or referral to an appropriate program or programs. This program type does not include warm lines or hot lines. Use Advocacy/Support 1760 for such services.

This program code should **not be used for services that are provided** by a licensed outpatient program.

Units of Service: Count the total staff hours.

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Non Medicaid Care Coordination Program Description

2720 Non-Medicaid Care Coordination; (Non-Licensed Program)

Activities aimed at linking the consumer to the service system and at coordinating the various services in order to achieve a successful outcome. The objective of care coordination in a mental health system is continually of care and service. Services may include linking, monitoring and case specific advocacy. Care coordination Services are provided to enrolled consumers for whom staff are assigned a continuing care coordination responsibility. Thus, routine referral would not be included unless the staff member making the referral retains a continuing active responsibility for the consumer throughout the system of service. Persons receiving Medicaid may receive services from this program, however, the program does not receive reimbursement from Medicaid for services provided.

Units of Service: Staff hours: The number of staff hours spent by staff in providing care coordination face-to-face or by telephone directly to recipients or collaterals. Count the total number of staff hours.

2750 Recovery Center (Non-Licensed Program)

A program of peer support activities that are designed to help individuals with psychiatric diagnosis live, work and fully participate in communities. These activities are based on the principle that people who share a common condition or experience can be of substantial assistance to each other. Specific program activities will: build on existing best practices in self-help/peer support/mutual support; incorporate the principles of Olmstead; assist individuals in identifying, remembering or discovering their own passions in life; serve as a clearinghouse of community participation opportunities; and then support individuals in lining to those community groups, organizations, networks or places that will nurture and feed an individual's passions in life. Social recreation events with a focus on community participation opportunities will be the basis for exposing individuals to potential passion areas through dynamic experiences, not lectures or presentations. This program will be funded through performance-based contracts with a specified set of deliverables.

Units of Service: Is measured by Staff hours.

2770 - Self Help Program (Non-Licensed Program)

To provide rehabilitative and support activities based on the principle that people who share a common condition or experience can be of substantial assistance to each other. These programs may take the form of mutual support groups and networks, or they may be more formal self-help organizations that offer specific educational, recreational, social or other program opportunities.

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- Direct staff hours: The number of staff hours spent by staff in providing case management services face-to-face or by telephone directly to consumers or collaterals.
- Indirect staff hours: The number of staff hours spent by staff in providing case management services on behalf of consumers other than face-to-face or by telephone directly with consumers or collaterals.

Units of Service: Count the number total number of staff hours (combine direct and indirect).

2780 - Compulsive Gambling Treatment (Non-Licensed Program)

To provide outpatient treatment to compulsive gamblers designed to reduce symptoms, improve functioning and provide ongoing support. A compulsive gambling treatment program shall provide assessment and treatment planning specific to compulsive gambling, screening and referral for other problems, financial management planning, connection to self help groups for compulsive gamblers, individual, group and family therapy specific to this diagnosis and crisis intervention.

Units of Service: Count the total number of visits.

2790 - Compulsive Gambling Education, Assessment and Referral Services (Non-Licensed Program)

To participate in the statewide public information campaign, assess the existence of compulsive gambling and make referrals and linkages to compulsive gambling treatment programs, other human services, and self help groups for compulsive gamblers.

Units of Service: Count the number of direct staff hours.

Medicaid Model Service Dollar Program Descriptions

2810 Case Management Service Dollars Administration; (Non-Licensed)

The Case Management Service Dollar Administration program code is to be used to report administration costs or Representative Payee Service costs for ICM, SCM, BCM, ACT, and AHSCM service dollar programs.

Units of Service: Not applicable.

2820 – Consumer Service Dollars (Non ICM/SCM/BCM/ACT) See Flexible Recipient Service Dollars (1230). (Non-Licensed Program) See RTF/HCBS Service Dollars (2980)

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2830 - Intensive Case Management/Supportive Case Management/Blended Case Management Emergency and Non-Emergency Service Dollars (Non-Licensed Program) See ICM Service Dollars (1910), SCM Service Dollars (6910), AHSCM Service Dollars (6920), BCM Service Dollars (0920)

2860 - Conference of Mental Hygiene Directors (Non-Licensed Program)

This program code represents funds used by the Conference of Local Mental Hygiene Directors. Agency administrative costs allocated to the operating costs of this program via the Ratio Value allocation methodology are redistributed to other OMH programs in the CFR.

Units of Service: Not applicable.

2880 Residential Treatment Facility (RTF) Transition Coordinator; (Non-Licensed Program)

RTF Transition Coordinators enhance the RTF's ability to ensure timely, successful discharges by providing support, case management, coordination and linkage to services for children from an RTF, regardless of whether the discharge is planned or unplanned. The staff to inpatient bed ratio is 1 to 12 and is expected to provide needed services both within the RTF and in the child's home community. It is expected that approximately one-fourth of their caseload is in post discharge status. RTF Transition Coordinators have access to RTF/HCBS Service Dollars to be used as payment of last resort. The purpose of the service dollar is to provide funds to facilitate the child's discharge plans.

Units of Service: Each consumer served during a month counts as one unit. Total Units of Service: Total the number of consumer units.

2980 RTF/HCBS Service Dollars; (Non-Licensed)

RTF Transition Coordinators and HCBS have access to "service dollars." All service dollar programs are for emergency and non-emergency purposes and are to be used as payment of last resort. The purpose of the service dollar is to provide funds for recipients' immediate and/or emergency needs. The use of service dollars in any of these programs should include participation of the recipient of services, who should play a significant role in the planning for, and the utilization of, service dollars. Also, as the needs of the recipient change, the money can be redirected to purchase the type of service that is currently needed. Services purchased on behalf of a recipient, such as Respite or Crisis Services, should be reported using the appropriate Service Dollar program code.

Units of Service: Count the number of recipients utilizing these funds.

2990 - Coordinated Children's Services Initiative

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(Non-Licensed Program)

The Coordinated Children's Services Initiative (CCSI) is an interagency initiative that supports localities in creating a system of care to provide structure and flexibility to ensure that children who are at risk of residential placement remain at home with their families and in their communities. The program exists at a local community level (Tier I), County level (Tier II) and State level (Tier III). These children are most often those with serious emotional disturbance. Principles are based on the Child and Adolescent Services System.

Units of Service: Count the total number of paid staff hours.

**3010 – Inpatient Psychiatric Unit of a General Hospital
(Licensed Program)**

A licensed, 24 hr. inpatient treatment program, that is jointly licensed by the New York State Office of Mental Health and the New York State Department of Health and operated in a medical hospital. Includes full-time medical, psychiatric and social services and around-the-clock nursing services for individuals with mental illness.

Units of Service: Count one patient day as one unit.

**3040 – Home-Based Crisis Intervention
(Non-Licensed Program)**

The Home-Based Crisis Intervention Program is a clinically oriented program with support services by a MSW or Psychiatric Consultant which assists families with children in crisis by providing an alternative to hospitalization. Families are helped through crisis with intense interventions and the teaching of new effective parenting skills. The overall goal of the program is to provide short-term, intensive in-home crisis intervention services to a family in crisis due to the imminent risk of their child being admitted to a psychiatric hospital. The target population for the HBCI Program is families with a child or adolescent ages 5 to 17 years of age, who are experiencing a psychiatric crisis so severe that unless immediate, effective intervention is provided, the child will be removed from the home and admitted to a psychiatric hospital. Families referred to the program are expected to come from psychiatric emergency services.

Units of Service: Total number of paid staff hours.

**3070 - Shelter Plus Care Housing
(Non-Licensed Program)**

A federally-funded program of housing assistance specifically targeted to the homeless mentally ill. Funds may be used for the payment of rent stipends up to the federally-established Fair Market rent, and associated administrative expenses. OMH requires any not-for-profit agency in receipt of these funds to report the funds in a separate program column. Shelter Plus Care

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Grants are made for five years at a time. Renewals are for one year only. This program code is used in cases where the federal funds flow through OMH. In cases where the funds do not flow through OMH, see program code 2070.

Units of Service: Not applicable.

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3130 – CPEP Crisis Intervention (Licensed Program)

This licensed, hospital-based psychiatric emergency program establishes a primary entry point to the mental health system for individuals who may be mentally ill to receive emergency observation, evaluation, care and treatment in a safe and comfortable environment. Emergency visit services include provision of triage and screening, assessment, treatment, stabilization and referral or diversion to an appropriate program. Brief emergency visits require a psychiatric diagnostic examination and may result in further CPEP evaluation or treatment activities, or discharge from the CPEP program. Full emergency visits, which result in a CPEP admission and treatment plan, must include a psychiatric diagnostic examination, psychosocial assessment and medication examination. Brief and full emergency visit services are Medicaid reimbursable.

CPEP Crisis Intervention is one of four program components which, when provided together, form the OMH licensed Comprehensive Psychiatric Emergency Program (CPEP), and the code to which the license is issued. The other program components of the CPEP are: CPEP Extended Observation Beds (1920), CPEP Crisis Outreach (1680) and CPEP Crisis Beds (2600).

Units of Service:

- Brief Emergency Visit
- Full Emergency Visit

Count the total number of visits.

3340 - Work Program (Non-Licensed Program)

The objective is to provide vocational assessment, training and transitional or long-term paid work in institutional or community job sites for individuals disabled by mental illness. Paid by the vocational services provider.

Units of Service: Count the total number of staff hours.

3990 - Multicultural Initiatives (Non-Licensed Program)

Funds will support activities related to the development and operation of outreach interventions in under-served communities and to address disparities based upon culture, ethnicity, age, or gender. Efforts by service providers will include the cultural and linguistic competence of their programs, management and staff.

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Units of Service: Count the total number of staff hours.

**4040 - Teaching Family Home
(Licensed Program)**

The Teaching Family Homes are designed to provide individualized care to children and youth with serious emotional disturbances in a family-like, community-based environment. Specially trained parents live and work with four children and youth with serious emotional disturbances in a home-like setting. The teaching parents are responsible for the social education of the children and the implementation of a service plan developed in conjunction with the family and clinical service provider. The focus is on teaching the youth to live successfully in a family, attend school, and live productively in the community.

This is a type of Licensed Housing/Community Residential program for children and adolescents as defined in 14NYCRR594.

Units of Service: Count each resident day.

**4340 - Ongoing Integrated Supported Employment Services
(Non-Licensed Program)**

These funds are intended for ongoing job maintenance services including job coaching, employer consultation, and other relevant supports needed to assist an individual in maintaining a job placement. These services are intended to complement VESID time-limited supported employment services.

Units of Service: Count the total number of staff hours.

**5070 - Supported Single Room Occupancy (SP-SRO)
(Non-Licensed Program)**

A single-room occupancy residence which provides long term or permanent housing in a setting where residents can access the support services they require to live successfully in the community. Front desk coverage is provided 24 hours per day. Mental health service supports are provided either by SP-SRO staff or nonresidential service providers in accordance with a service plan developed jointly by the provider and resident.

Units of Service: Resident day.

**5340 - Supported Education
(Non-Licensed Program)**

The objective of this program is to provide mental health and rehabilitation services to individuals with a serious mental illness to assist them to develop and achieve academic goals

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in natural and community-based educational settings. The emerging program models for delivering this service include free-standing career development and exploration programs housed on college campuses, ongoing counseling and support by a mental health provider to enrolled students, and collaborative relationships between mental health and oncampus services to students with disabilities. Funding is to cover mental health staff and related costs.

Units of Service: Count the total number of paid staff hours.

**5990 – MICA Network
(Non-Licensed Program)**

The proposed network must define a service area, a target population and ensure that MICA consumers have access to housing, treatment, peer support/self-help and alcohol/substance abuse services and case management. A MICA Network would include, but not be limited to: residential capacity, case management, psycho-social capacity, enhancement of treatment capacity, self-help, peer leadership/peer specialist/peer case management, linkages with drug and alcohol providers.

Units of Service: Count the total number of paid staff hours.

**6050 - Supported Housing Rental Assistance
(Non-Licensed Program)**

Rental assistance is provided to residents of supported housing programs through the means of a voluntary agency-administered rent stipend mechanism. Residents are expected to contribute 30% of their income toward the cost of rent and utilities in decent, moderately priced housing in the community; the difference between the residents' contribution and the actual cost of the housing is paid directly to the landlord on behalf of the program residents.

Units of Service: Count one resident day as one unit.

**6060 - Supported Housing Community Services
(Non-Licensed Program)**

This includes all services provided to residents of supported housing programs by the supported housing agency, excluding rental assistance. The objective of the program is to assist individuals in locating and securing housing of their choice and in accessing the supports necessary to live successfully in the community. Services may include assistance with choosing housing, roommates, and furniture; providing financial assistance with purchasing apartment furnishings and with initial apartment/utility deposits, assistance with resolving roommate or landlord issues that may jeopardize the stability of the housing placement; and linking residents to a comprehensive community support system of case management, mental health and general health supports.

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Units of Service: Count each contact as one unit.

**6070 - Treatment Congregate
(Licensed Program)**

A group-living designed residential program which focuses on interventions necessary to address the specific functional and behavioral deficits which prevent residents from accessing generic housing. These interventions are goal-oriented, intensive, and usually of limited duration. Staff is on-site 24 hours/day.

This is a type of Licensed Housing/Community Residential program for adults as defined in 14NYCRR595.

Units of Service: Count one resident day as one unit.

**6080 - Support Congregate
(Licensed Program)**

A single-site residential program which provides support designed to improve or maintain an individual's ability to live as independently as possible and eventually access generic housing. Interventions are provided consistent with the resident's desire, tolerance and capacity to participate in services. Staff is on-site 24 hours/day.

Units of Service: Count one resident day as one unit.

**6340 - Comprehensive PROS with Clinic
(Licensed Program)**

Personalized Recovery Oriented Services (PROS) is a comprehensive recovery oriented program for individuals with severe and persistent mental illness. The goal of the program is to integrate treatment, support and rehabilitation in a manner that facilitates the individual's recovery. Goals for individuals in the program are to: improve functioning, reduce inpatient utilization, reduce emergency services, reduce contact with the criminal justice system, increase employment, attain higher levels of education and secure preferred housing. There are four "service components" in the program: Community Rehabilitation and Support (CRS), Intensive Rehabilitation (IR), Ongoing Rehabilitation and Support (ORS) and Clinical Treatment.

Units of Service: Count the Pros units

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6810 Supportive Case Management (SCM); (Non-Licensed Program)

In addition to the general Targeted Case Management program description located in the Spending Plan Guidelines, SCM is set at a case manager client ratio of 1:20 or 1:30. The SCM models require a minimum of two (2) 15 minute face-to-face contacts per individual, per month, collateral contacts are not counted.

Units of Service: Count the total number of contacts.

6820 Adult Home Supportive Case Management (AHSCM); (Non-Licensed Program)

In addition to the general Targeted Case Management program description located in the Spending Plan Guidelines, SCM is provided to adult home residents by Supportive Case Managers who work in tandem with Peer Specialists as part of an integrated approach to addressing the needs of the Adult Home population. Each Case Manager and Peer Specialist team serves a maximum of 30 residents. A Supervising Case Manager or Coordinator of Case Management provides supervision to the SCM and Peer Specialists. Adult Home Case Management takes referrals from the Adult Home and does not take referrals from SPOA.

When an Adult Home resident moves to other community housing and no longer needs SCM, the recipient will then be eligible for transitional status, receiving one visit per month for billing (this status may be active for a maximum of two months). When an Adult Home resident moves to other community housing and continues to need the SCM level of care (or the higher ICM level), it is expected that a request for community case management enrollment is processed through the local SPOA. Where a community case management waiting list exists, the Adult Home Case Management program can continue to support that person in the other community setting until the person is transferred to community case management. If the recipient is enrolled in community case management at the time of the move out of the Adult Home, the recipient is not eligible to transitional status.

Medicaid billing requires a minimum of two 15 minute face-to-face contacts per month. Collateral contacts are not billable.

Units of Service: Count the total number of contacts.

6910 SCM Service Dollars; (Non-Licensed)

All Supportive Case Management (SCM) programs have access to “service dollars.” All service dollar programs are for emergency and non-emergency purposes and are to be used as payment of last resort. The purpose of the service dollar is to provide funds for recipients’ immediate and/or emergency needs. The use of service dollars in any of these programs should include participation of the recipient of services, who should play a significant role in the planning for, and the utilization of, service dollars. Also, as the needs of the recipient change, the money can be redirected to purchase the type of service that is currently needed. Services

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purchased on behalf of a recipient, such as Respite or Crisis Services, should be reported using the appropriate Service Dollar program code.

Units of Service: Count the number of recipients utilizing these funds.

6920 Adult Home Service Dollars; (Non-Licensed)

All Adult Home Supportive Case Management (AHSCM) programs have access to “service dollars.” All service dollar programs are for emergency and non-emergency purposes and are to be used as payment of last resort. The purpose of the service dollar is to provide funds for recipients’ immediate and/or emergency needs. The use of service dollars in any of these programs should include participation of the recipient of services, who should play a significant role in the planning for, and the utilization of, service dollars. Also, as the needs of the recipient change, the money can be redirected to purchase the type of service that is currently needed. Services purchased on behalf of a recipient, such as Respite or Crisis Services, should be reported using the appropriate Service Dollar program code.

Units of Service: Count the number of recipients utilizing these funds.

**7050 - Community Residence, Children & Youth
(Licensed Program)**

A Community Residence which provides a supervised, therapeutic environment for six to eight children or adolescents, between the ages of 5 and 18 years, that includes structured daily living activities, problem solving skills development, a behavior management system and caring consistent adult interactions. Most often, needed clinical supports for the child and family are provided by community-based services.

This is a type of Licensed Housing/Community Residential program for children and adolescents as defined in 14NYCRR594.

Units of Service: Count one resident day as one unit.

**7070 - Treatment Apartment
(Licensed Program)**

An apartment-based residential program which focuses on interventions necessary to address the specific functional and behavioral deficits which prevent residents from accessing generic housing. These interventions are goal-oriented, intensive, and usually of limited duration. Resident/staff contacts occur on a flexible schedule, as appropriate to the needs and desires of the resident.

This is a type of Licensed Housing/Community Residential program for adults as defined in 14NYCRR595.

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Units of Service: Count one resident day as one unit.

**7080 - Support Apartment
(Licensed Program)**

An apartment-based residential program which provides support designed to improve or maintain an individual's ability to live as independently as possible, and eventually access generic housing. Interventions are provided consistent with the resident's desire, tolerance, and capacity to participate in services. Resident/staff contacts occur on a flexible schedule, as appropriate to the needs and desires of the resident.

This is a type of Licensed Housing/Community Residential program for adults as defined in 14NYCRR595.

Units of Service: Count one resident day as one unit.

**7340 - Comprehensive PROS without Clinic
(Licensed Program)**

Personalized Recovery Oriented Services (PROS) is a comprehensive recovery oriented program for individuals with severe and persistent mental illness. The goal of the program is to integrate treatment, support and rehabilitation in a manner that facilitates the individual's recovery. Goals for individuals in the program are to: improve functioning, reduce inpatient utilization, reduce emergency services, reduce contact with the criminal justice system, increase employment, attain higher levels of education and secure preferred housing. There are four "service components" in the program: Community Rehabilitation and Support (CRS), Intensive Rehabilitation (IR), Ongoing Rehabilitation and Support (ORS) and Clinical Treatment. This program does not include the optional Clinic Treatment component.

Units of Service: Count the PROS units

**8050 - Community Residence Single Room Occupancy (CR-SRO)
(Licensed Program)**

The single room occupancy residence which provides long-term housing where residents can access the support services they require to live successfully in the community and to eventually move to other residential settings. Front desk coverage is provided 24 hours per day. Mental health services are provided either by program staff or non-residential service providers, according to a plan which is developed jointly by the provider and resident. Individuals may remain in residence as long as the services provided in the program are needed.

This is a type of Licensed Housing/Community Residential program for adults as defined in 14NYCRR595.

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Units of Service: Count one resident day as one unit.

**8340 - Limited License PROS
(Licensed Program)**

Personalized Recovery Oriented Services (PROS) is a comprehensive recovery oriented program for individuals with severe and persistent mental illness. The goal of the program is to integrate treatment, support and rehabilitation in a manner that facilitates the individual's recovery. Goals for individuals in the program are to: improve functioning, reduce inpatient utilization, reduce emergency services, reduce contact with the criminal justice system, increase employment, attain higher levels of education and secure preferred housing. A Limited License PROS program provides only Ongoing Rehabilitation and Support (ORS) and Intensive Rehabilitative Services (IR).

Units of Service: Count the PROS Units

8810 Assertive Community Treatment Service Dollars; (Non-Licensed)

All Assertive Community Treatment (ACT) programs have access to “service dollars.” All service dollar programs are for emergency and non-emergency purposes and are to be used as payment of last resort. The purpose of the service dollar is to provide funds for recipients’ immediate and/or emergency needs. The use of service dollars in any of these programs should include participation of the recipient of services, who should play a significant role in the planning for, and the utilization of, service dollars. Also, as the needs of the recipient change, the money can be redirected to purchase the type of service that is currently needed. Services purchased on behalf of a recipient, such as Respite or Crisis Services, should still be reported using the appropriate Service Dollar program code.

Units of Service: Count the number of recipients utilizing these funds.

**9340 - PROS Rehabilitation and Support Subcontract Services
(Non-Licensed Program)**

Services provided under a contract arrangement to a licensed PROS. A PROS may find it more effective to purchase certain services from another provider. The provider of services would use this code to report the costs of providing those services and the revenue received from the PROS for the purchase of those services.

Units of Service: Count the total number of direct care hours.

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Below is an alphabetical listing of program types and the corresponding codes. Following this alphabetic list is a numeric list of program definitions and the corresponding codes.

<i>Program Name</i>	<i>Program Code</i>
Care At Home - III	1220
Care at Home - IV & VI	2220
Case Management (Non-Medicaid)	0810
Certified Work Activity/Sheltered Workshop	0340
Classroom Education	0360
Community Residence, Part 671, Supervised Residential Habilitation	0053
Community Residence, Part 671, Supervised Room & Board	0054
Community Residence, Part 671, Supportive Residential Habilitation	1053
Community Residence, Part 671, Supportive Room & Board	1054
Consumer Transportation	0670
Crisis Intervention	0060
Day Program Services Included in the ICF/DD Reimbursement Rate (Off-Site)	6091
Day Program Services Included in the ICF/DD Reimbursement Rate (On-Site)	6090
Day Training	0330
Day Treatment – Free Standing	0200
Day Treatment – Partial	0202
Developmental Disabilities Program Council Grant	2190
Epilepsy Services	0414
Family Support Services	0150
HCBS Adaptive Technologies	0216
HCBS Assistive Supports	0221
HCBS Consolidated Supports and Services	0411
HCBS Environmental Modifications	0215
HCBS Family Education and Training	0413
HCBS Freestanding Respite	0233
HCBS Group Day Habilitation Service	0223
HCBS Individual Day Habilitation Service	0225
HCBS Live-in Caregiver	0415
HCBS Other Than Freestanding Respite	0235
HCBS Prevocational Services (Services on or after 1/1/06)	0227
HCBS Residential Habilitation, At Home	0219
HCBS Residential Habilitation Family Care	0220
HCBS Supervised IRA (Room and Board and Residential Habilitation Services)	0231
HCBS Supplemental Group Day Habilitation Service	0224
HCBS Supplemental Individual Day Habilitation Service	0226
HCBS Supported Employment	0214
HCBS Supportive IRA (Room and Board and Residential Habilitation Services)	0232
HCBS Waiver Plan of Care Support Services	0416

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<i>Program Name</i>	<i>Program Code</i>
Homemaker Services	0630
ICF/DD (Over 30 Beds)	1090
ICF/DD (30 Beds or Less)	0090
Individualized Support Services	0410
Information & Referral	0750
Local Governmental Unit (LGU) Administration	0890
Medicaid Service Coordination	0229
NYC Housing Resource Consortium	0780
OPWDD Clinic Treatment Facility (Free-Standing Clinic)	0100
OPWDD Clinic Treatment Facility (Clinic Joint Venture)	0101
Options for People Through Services (NYS OPTS)	0234
Other Service Coordination (Non-Medicaid)	0222
Preschool Program	0370
Program Development Grant	0190
Recreation	0610
Residential School	0080
Shelter Plus Care Housing	3070
SOICF Sheltered Workshop/Day Training	4090
Special Legislative Grant	1190
Specialty Clinic	0120
Subcontract Services	0880
Summer Camp	0070
Supported Employment (Non-HCBS Waiver)	0390
Temporary Use Beds (TUBS) in an Intermediate Care Facility (30 Beds or Less)	0091
Temporary Use Beds (TUBS) in an Intermediate Care Facility (Over 30 Beds)	1091
Transitional Employment	0380
Traumatic Brain Injury (TBI)	1150
VOICF/DD, Day Services Contract	7090
VOICF/DD, Day Services (Not Operated by Service Provider)	7091
VOICF/DD, Day Training	5090
VOICF/DD, Day Training (Not Operated by Service Provider)	5091
VOICF/DD, School District Contract	3090
VOICF/DD, School District Contracts (Not Operated by Service Provider)	3091
VOICF/DD, Sheltered Workshop	2090
VOICF/DD, Sheltered Workshop (Not Operated by Service Provider)	2091
Voluntary Preservation Project – Formerly Known as Voluntary Operated Maintenance ,Project (aka VAMM)	1850

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0053 - Community Residence Part 671 Supervised - Residential Habilitation

A facility that provides 24 hour per day responsible supervision for the habilitation or rehabilitation of developmentally disabled persons as part of an overall service delivery system. Expenses for the following may be included:

- Personal Services
- Vacation Leave
- Mandated Fringe
- Non-mandated Fringe
- Transportation Related
- Staff Travel
- Contracted Direct Care and Clinical Care
- Other OTPS
- Provider Paid Equipment

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the site's Operating Certificate Number as the Program/Site Identification Number. For each Program Code 0053 column that is reported, there must be a corresponding Program Code 0054 column reported.

Note: Do not include Day Treatment/HCBS Day Habilitation To/From Transportation expense in this program. If a vehicle or staff person is assigned to this program, but is used for to/from transportation, the related expenses must be reported under Program Code 0670. See Program Code 0670 for instructions on reporting and allocating these expenses.

Units of Service: For each unit of service, count one participant day.

0054 - Community Residence Part 671 Supervised Room and Board

Room and Board. Report on a program/site specific basis.

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the site's Operating Certificate Number as the Program/Site Identification Number. For each Program Code 0054 column that is reported, there must be a corresponding Program Code 0053 column reported.

Report only those costs normally occurring in a room and board situation. Additional costs because program participants may have special needs are Res. Hab. costs.

Note: Do not include Day Treatment/HCBS Day Habilitation To/From Transportation expense in this program. If a vehicle or staff person is assigned to this program, but is used for to/from transportation, the related expenses must be reported under Program

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Code 0670. See Program Code 0670 for instructions on reporting and allocating these expenses.

Units of Service: For each unit of service, count one participant day.

0060 - Crisis Intervention

Those activities that assist persons with developmental disabilities and their families in dealing with specific and time-limited problems which threaten to disrupt the individual's residential situation and/or habilitation program. Such activities frequently include arranging for the provision of intensive behavioral services or other services such as respite care, health/medical services, nutrition services, counseling, legal services, and case management/service coordination.

Contract Budget consistent reporting is required for this program. The same number of columns use on the Consolidated Budget Report must be used on the CFR so that reporting is consistent.

The Program/Site Identification Number is created by using the first four digits of the Agency Code and the last three digits of the Program Code. Where more than one column will be created for this Program Code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: One hour equals one unit of service.

0070 - Summer Camp

A program certified by the Department of Health in accordance with sub-part 7-2 of Chapter 1 of the State Sanitary Code (Title X NYCRR) which provides overnight accommodations for periods of occupancy of more than 48 continuous hours. Such camps provide for the physical needs of campers and also implement a program of organized activities for the purpose of recreation and enhancement of the intellectual, sensorimotor and effective development of the participants.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent.

The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: For each unit of service, count one participant day.

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For Budget Format: Count each participant day as one day.

0080 - Residential School

A non-publicly operated residential facility or institution providing a program of 24 hour professional care and treatment for developmentally disabled persons that is certified in accordance with Part 81 of Title 14 of NYCRR.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Units of Service: For each unit of service, count one participant day.

For Budget Format: Count each participant day as one day.

0090 - Intermediate Care Facility for the Developmentally Disabled (30 beds or less)

A facility operated by or subject to certification by the Office for People with Developmental Disabilities with a capacity of up to 30 in accordance with the requirements of Part 681 of Title 14 NYCRR and 42 CFR 442. Such facilities provide active programming, room and board, and continuous 24 hour per day supervision. They are located within the population areas of non-developmentally disabled persons. They are not of the facility type known as developmental center or school as defined by Section 13.17 of the Mental Hygiene Law.

If this Program Code is reported, a corresponding OPWDD-1, ICF/DD Schedule of Service, must be completed.

Note: When the ICF/DD rate includes an add-on component for an ICF/DD School contract, report all expense and revenue in a discreet column as program code 3090 OR 3091 as appropriate. Add-on for ICF/DD Sheltered Workshop - use program code 2090 or 2091 as appropriate. Add-on for ICF/DD Day Training - use program code 5090 or 5091 as appropriate. When the ICF/DD rate includes funding for day program services, report all expense in a discreet column as Program Code 6090, Day Program Services Included in the ICF/DD Reimbursement Rate (On-Site) or Program Code 6091, Day Program Services Included in the ICF/DD Reimbursement Rate (Off-Site). Add-on for VOICF/DD, Day Services Contract – use program code 7090 or 7091 as appropriate.

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the site's Operating Certificate Number as the Program/Site Identification Number.

Note: Do not include Day Treatment/HCBS Day Habilitation To/From Transportation expense in this program. If a vehicle or staff person is assigned to this program, but is

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used for to/from transportation, the related expenses must be reported under Program Code 0670. See Program Code 0670 for instructions on reporting and allocating these expenses.

Units of Service: For each unit of service, count one participant day.

For Budget Format: Count each participant day as one day.

0091 – Temporary Use Beds (TUBS) in an Intermediate Care Facility (30 Beds or Less)

When a bed (certified or uncertified) in an ICF/DD (30 beds or less) is used as a temporary use bed, the associated revenues and expenses should be reported under this program code. (Do not report the same revenue and expense under program code 0090 – Intermediate Care Facility (30 beds or less).) Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the site's Operating Certificate Number as the Program/Site Identification Number.

Units of Service: One hour of service equals one unit of service.

0100 – OPWDD Clinic Treatment Facility (Free-Standing Clinic)

A certified physical space or setting and/or its services, including any certified satellite location(s) providing clinical services pursuant to Part 679, principally to persons with developmental disabilities, where such services are provided on an outpatient (i.e., non-residential) basis. The term "facility" also includes the headquarters for administration, management (including clinical records management), and clinician office (but not treatment) space for a provider authorized to provide exclusively off-site services, which holds an appropriate certificate of occupancy in accordance with the requirements of locality having jurisdiction.

Note: Off-site Services are services delivered at any location(s) other than the clinic's **main site** or a certified **satellite site**.

For this program type, reporting is required based on operating certificate number, which should be used as the Program/Site Identification Number. All costs and services associated with an operating certificate number, including satellite(s) and off-site services, should be included in one column.

Units of Service: Units of Service as defined (Part 679.5) is an allowable clinic service delivered at the main certified site, or at a certified satellite site or as an Off-site service. There is only one (1) billable visit per day per person regardless of the number of services provided during a given visit.

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0101 – OPWDD Clinic Treatment Facility (Clinic Joint Venture)

A Clinic Joint Venture is defined as a Voluntary operated Clinic Treatment Facility certified as a STATE clinic satellite on the local DDSO state-operated clinic operating certificate. There is a formal contractual arrangement between a DDSO and a Voluntary Provider to operate a Clinic Treatment Facility as a Clinic Satellite of the DDSO.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the Program Code.

All costs and services associated with this satellite and any other additional certified satellites under this affiliation should be included in this cost center. Reimbursement received should be reported as Net Deficit Funding.

Units of Service: Units of Service as defined (Part 679.5) is an allowable clinic service delivered at the main certified site, or at a certified satellite site or as an Off-site service. There is only one (1) billable visit per day per person regardless of the number of services provided during a given visit.

0120 - Specialty Clinic

Intensive diagnosis and/or medically prescribed treatment services provided during day and/or evening hours to mentally retarded and developmentally disabled persons who are served as needed for short periods of actual service involvement. Such programs are affiliated with a hospital or facility which holds, in addition to OPWDD certification, certification in accordance with Article 28 of the Public Health Law. The rates for payment and duration of visit are cost-related and determined in accordance with procedures established by the Office of Health Systems Management for the specific facility and the particular service being offered.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent.

The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: Count each billable visit as one unit of service.

0150 - Family Support Services

Those services other than basic residential and habilitative services needed by people with developmental disabilities to sustain themselves in appropriate community settings. They

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also include those services that families with disabled members need to provide environmental supports and maintenance of family stability and integrity. Family Support Services typically include information and referral, parent training, family counseling, recreation, home-based care, adaptive equipment and home modification, and legal services.

List free standing respite programs separately under 0650.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: As per contract.

For Budget Format: As per contract.

0190 - Program Development Grants

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. Include the name and address of the site that is being developed. Include the operating certificate, if known, as the Program/Site Identification Number. If the operating certificate number is not known, create a Program/Site Identification Number by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: Not applicable.

0200 - Day Treatment Free Standing

A planned combination of diagnostic, treatment, and rehabilitative services provided to mentally retarded and developmentally disabled individuals in need of a broader range of services than those provided in clinic treatment programs. Persons provided day treatment will attend regularly for periods in excess of three hours. Day Treatment Programs may vary widely in the services offered, the level of disability of participants, the staffing plan, the program goals and the types and numbers of cooperative agency relationships. Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the site's Operating Certificate Number as the Program/Site Identification Number.

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Revenue for transportation to and from Day Treatment should be reported as “Transportation, Medicaid” (CFR-1, Line 76) for Medicaid eligible consumers and/or “Transportation, Other” (CFR- 1, Line 77) for non-Medicaid eligible consumers.

See Program Codes 0670 and 0880 for specifics on reporting expenses regarding transportation to and from Day Treatment.

Note: Do not include Day Treatment/HCBS Day Habilitation To/From Transportation expense in this program. If a vehicle or staff person is assigned to this program, but is used for to/from transportation, the related expenses must be reported under Program Code 0670. See Program Code 0670 for instructions on reporting and allocating these expenses.

Units of Service:

Half-day visit: 3 but less than 5 hours.

Full-day visit: 5 hours or more.

0202 - Day Treatment Partial

Same as 0200 preceding, except available only in co-located setting with an emphasis on some subcontract work being performed.

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the site’s Operating Certificate Number as the Program/Site Identification Number.

Units of Service: One unit = 1.5 hours but less than 3 hours

0214 - HCBS Supported Employment

Supported Employment services assist people in finding and keeping employment that the person finds meaningful. It provides appropriate staff and/or supports to help individuals obtain and maintain paid employment. The service takes place in integrated work settings in the community, which provide opportunities for regular interactions with individuals who do not have disabilities and who are not paid to provide services to people with a developmental disability.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Units of Service: One month of service equals one unit of service.

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215 - HCBS Environmental Modifications

Selected internal and external changes to the person's physical home environment, required by the person's individualized service plan, which are necessary to ensure the health, welfare and safety of the person of which enable him or her to function with greater independence in the home and without which the person would require institutionalization. Environmental modifications will be provided on a limited one-time only basis to the extent necessary to enable people with physical infirmities and disabilities to live safely in community homes outside the institutional setting. Report all similar services as one program/site. The revenue is reported as Medicaid.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

100% of Environmental Modification cost is to be reported as Equipment or Property-Other as appropriate. If property or equipment belongs to the service provider, the cost will be depreciated on the service provider's books and will be a reconciling item since 100% of the cost is reported in the first year.

Units of Service: Not applicable.

0216 - HCBS Adaptive Technologies

The provision of devices, aids, controls, appliances or supplies of either a communication or adaptive type determined necessary to enable the person to increase his or her ability to function in a home and community based setting with independence and safety. The aid, whether of a communication or adaptive type, must be documented in the person's individualized service plan as being essential to the person's habilitation, ability to function or safety, and essential to avoid or delay more costly institutional placement. Report all similar services as one program/site. The revenue is reported as Medicaid.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Units of Service: Not applicable.

0219 - HCBS Residential Habilitation Service (At Home)

Residential habilitation services are provided in the person's place of residence. This includes assistance with acquisition, retention or improvements of self-help skills related to activities of daily living, such as personal grooming and cleanliness, bed-making and household chores, eating and the preparation of food, and the social and adaptive skills

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necessary to enable the individual to reside in a non-institutional setting. Do not include any expenses for programming provided as day habilitation.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Units of Service: Contact during one 24-hour period, regardless of duration, equals one unit of service.

0220 - HCBS Residential Habilitation Services (Family Care)

Residential habilitation services are provided in the person's place of residence. This includes assistance with acquisition, retention or improvements of self-help skills related to activities of daily living, such as personal grooming and cleanliness, bed-making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Do not include any expenses for programming provided as day habilitation. The Difficulty of Care (DOC) payment should be reported as a Contracted Direct Care Personal Services expense.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Units of Service: One participant day equals one unit of service.

0221 - HCBS Assistive Supports

Assistive supports includes support staff for an individual or family with assistance and/or training in order to enhance the independence of the individual. Assistive supports must be included in the individual's service plan. Report all similar services as one program/site.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Units of Service: Not applicable.

0222 - Other Service Coordination (Non-Medicaid)

A service which assists persons with developmental disabilities and mental retardation in gaining access to necessary services and supports appropriate to the needs of the individual. Other Service Coordination is provided by qualified service coordinators and uses

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a person centered planning process in developing, implementing, and maintaining an Individualized Service Plan (ISP) with and for a person with developmental disabilities or mental retardation. Other Service Coordination promotes the concepts of choice, individualized services and supports, and consumer satisfaction and is designed for individuals who are non-Medicaid eligible. The revenue is reported as “Other, Mirrored Services.”

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Units of Service: One month of service equals one unit of service.

0223 - HCBS Group Day Habilitation Service

HCBS day habilitation provides assistance with acquisition, retention or improvement of self-help, socialization and adaptive skills. Group Day Habilitation services are typically provided to two or more enrolled consumers on weekdays and have a service start time prior to 3:00 p. m.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Revenue for transportation to and from HCBS Group Day Habilitation should be reported as “Transportation, Medicaid” (CFR-1, line 76) for Medicaid eligible consumers and/or “Transportation, Other” (CFR-1, line 77) for non-Medicaid eligible consumers. See Program Codes 0670 and 0880 for specifics on reporting expenses regarding transportation to and from HCBS Day Habilitation.

Note: Do not include Day Treatment/HCBS Day Habilitation To/From Transportation expense in this program. If a vehicle or staff person is assigned to this program, but is used for to/from transportation, the related expenses must be reported under Program Code 0670. See Program Code 0670 for instructions on reporting and allocating these expenses.

Units of Service:

Half Unit: 2 or more hours with at least one face-to-face service

Full Unit: 4 to 6 hours with at least two face-to-face services

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0224 - HCBS Supplemental Group Day Habilitation Service

HCBS day habilitation provides assistance with acquisition, retention or improvement of self-help, socialization and adaptive skills. Supplemental Group Day Habilitation services are typically provided to two or more enrolled consumers on weekdays with a service start time at 3:00 p. m. or later or anytime on weekends.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Revenue for transportation to and from HCBS Group Day Habilitation should be reported as “Transportation, Medicaid” (CFR-1, line 76) for Medicaid eligible consumers and/or “Transportation, Other” (CFR-1, line 77) for non-Medicaid eligible consumers.

See Program Codes 0670 and 0880 for specifics on reporting expenses regarding transportation to and from HCBS Day Habilitation.

Note: Do not include Day Treatment/HCBS Day Habilitation To/From Transportation expense in this program. If a vehicle or staff person is assigned to this program, but is used for to/from transportation, the related expenses must be reported under Program Code 0670. See Program Code 0670 for instructions on reporting and allocating these expenses.

Units of Service:

Half Unit: 2 or more hours with at least one face-to-face service

Full Unit: 4 to 6 hours with at least two face-to-face services

0225 - HCBS Individual Day Habilitation Service

HCBS day habilitation provides assistance with acquisition, retention or improvement of self-help, socialization and adaptive skills. Individual Day Habilitation services are provided with a staff-to-consumer ratio of no greater than one consumer per staff member and are delivered on weekdays and have a service start time prior to 3:00 p. m.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

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Revenue for transportation to and from HCBS Group Day Habilitation should be reported as “Transportation, Medicaid” (CFR-1, line 76) for Medicaid eligible consumers and/or “Transportation, Other” (CFR-1, line 77) for non-Medicaid eligible consumers.

See Program Codes 0670 and 0880 for specifics on reporting expenses regarding transportation to and from HCBS Day Habilitation.

Note: Do not include Day Treatment/HCBS Day Habilitation To/From Transportation expense in this program. If a vehicle or staff person is assigned to this program, but is used for to/from transportation, the related expenses must be reported under Program Code 0670. See Program Code 0670 for instructions on reporting and allocating these expenses.

Units of Service: Report using billable units. (i.e.: one quarter hour equals one unit of service.)

0226 - HCBS Supplemental Individual Day Habilitation Service

HCBS day habilitation provides assistance with acquisition, retention or improvement of self-help, socialization and adaptive skills. Supplemental Individual Day Habilitation services are provided with a staff-to-consumer ratio of no greater than one consumer per staff member and are delivered on weekdays with a service start time at 3:00 p. m. or later or anytime on weekends.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Revenue for transportation to and from HCBS Group Day Habilitation should be reported as “Transportation, Medicaid” (CFR-1, line 76) for Medicaid eligible consumers and/or “Transportation, Other” (CFR-1, line 77) for non-Medicaid eligible consumers.

See Program Codes 0670 and 0880 for specifics on reporting expenses regarding transportation to and from HCBS Day Habilitation.

Note: Do not include Day Treatment/HCBS Day Habilitation To/From Transportation expense in this program. If a vehicle or staff person is assigned to this program, but is used for to/from transportation, the related expenses must be reported under Program Code 0670. See Program Code 0670 for instructions on reporting and allocating these expenses.

Units of Service: Report using billable units. (i.e.: one quarter hour equals one unit of service.)

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0227 - HCBS Prevocational Services (Services on or after 1/1/06)

Services that are aimed at preparing an individual for paid or unpaid employment, but which are not job task oriented. Services include teaching such concepts as compliance, attending, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate satisfactory in a transitional sheltered workshop within one year (excluding supported employment programs). Report all similar services as one program/site.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code

Units of Service:

Half Unit: 2 or more hours with at least one face-to-face service

Full Unit: 4 or more hours with at least two face-to-face services

0229 - Medicaid Service Coordination (MSC)

A service which assists persons with developmental disabilities and mental retardation in gaining access to necessary services and supports appropriate to the needs of the individual. MSC is provided by qualified service coordinators and uses a person centered planning process in developing, implementing, and maintaining an Individualized Service Plan (ISP) with and for a person with developmental disabilities or mental retardation. MSC promotes the concepts of choice, individualized services and supports, and consumer satisfaction. The revenue is reported as Medicaid.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Units of Service: One month of service equals one unit of service.

0231 - HCBS Supervised IRA (Room and Board and Residential Habilitation Services)

A Supervised IRA has staff onsite or proximately available at all times when the individuals are present.

Report expenses for both Room and Board and Residential Habilitation Services. This includes assistance with acquisition, retention or improvements of self-help skills related to activities of daily living, such as personal grooming and cleanliness, bed-making and

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household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting.

Residential habilitation services are provided in the person's place of residence. Do not include any expenses for programming provided as day habilitation. Do not include expenses for Residential Habilitation Services or Room and Board for HCBS Supportive IRAs or Part 671 Community Residences (Supervised or Supportive).

Program type reporting is required for this program. All program site expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the Agency Code and the last three digits of the Program Code.

Note: Do not include Day Treatment/HCBS Day Habilitation To/From Transportation expense in this program. If a vehicle is assigned to this program, but is used for to/from transportation, the related expenses must be reported under Program Code 0670. See Program Code 0670 for instructions on reporting and allocating these expenses.

Units of Service: One month of service equals one unit of service.

0232 - HCBS Supportive IRA (Room and Board and Residential Habilitation Services)

A Supportive IRA provides practice in independent living under variable amounts of oversight delivered in accordance with the individual's needs for supervision. Staff typically are not onsite nor proximately available at all times when the individuals are present.

Report expenses for both Room and Board and Residential Habilitation Services. This includes assistance with acquisition, retention or improvements of self-help skills related to activities of daily living, such as personal grooming and cleanliness, bed-making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting.

Residential habilitation services are provided in the person's place of residence. Do not include any expenses for programming provided as day habilitation. Do not include expenses for Residential Habilitation Services or Room and Board for HCBS Supervised IRAs or Part 671 Community Residences (Supervised or Supportive).

Program type reporting is required for this program. All program site expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the Agency Code and the last three digits of the Program Code.

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Note: Do not include Day Treatment/HCBS Day Habilitation To/From Transportation expense in this program. If a vehicle is assigned to this program, but is used for to/from transportation, the related expenses must be reported under Program Code 0670. See Program Code 0670 for instructions on reporting and allocating these expenses.

Units of Service: One month of service equals one unit of service.

0233 - HCBS Freestanding Respite

Provision of temporary, short-term relief for families and care providers which enables them to arrange for their vacations, emergency coverage in the event of family or provider illness or death, or for a break from constant, intensive participant care and supervision. This applies only to respite provided in a freestanding center authorized or certified by OPWDD.

Site specific reporting is required for this program type. Each site is reported separately in its own column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this Program Code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: Report using billable units. (i.e.: one quarter hour equals one unit of service.)

0234 - Options for People Through Services (NYS OPTS)

Report all expenses and revenues related to an approved contract established under the NYS OPTS program. The revenue should be reported on Line 75 of CFR-1 ("OPWDD Residential Room and Board/NYS OPTS") and the expenses are reported using all applicable expense line items.

Service Type reporting is required for this program. For each Service Type included in the contract there must be a separate column on the CFR. Use the contract number as the Program/Site Identification Number (use "0" to replace the starting letter of the contract in order to create a seven digit number). Use the two digit Service Type indicator as the index code.

OPTS Service Types: 01 Supervised IRA with Res Hab; 02 Supportive IRA with Res Hab; 03 Comp Res Hab/Supervised IRA; 04 Comp Res Hab/Supportive IRA; 05 Group Day Habilitation; 06 Individual Day Habilitation; 07 Pre-Vocational; 08 Blended DP; 09 At-Home Res Hab; 10 Hourly Respite; 11 Free Standing Respite; 12 Monthly Supported Employment (SEMP); 13 Family Care; 18 Supplemental Group Day Habilitation; 19 Blended DPS; 20 Blended PS; 22 General DD-Hourly; 23 General DD-Per Diem; 24 General DD-Monthly; 25 Supplemental Individual Day Habilitation; 26 General DD-Per Unit; 27 Blended DS; 99 Other.

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Note: For NYS OPTS approved contracts for the Day Habilitation Service Type: revenue for transportation to and from Day Habilitation should be reported as “Transportation, Medicaid” (CFR-1, Line 76) for Medicaid eligible consumers and/or “Transportation, Other” (CFR-1, Line 77) for non-Medicaid eligible consumers. Do not include Day Habilitation To/From Transportation expense in this program. If a vehicle or staff person is assigned to this program, but is used for to/from transportation, the related expenses must be reported under Program Code 0670. See Program Codes 0670 and 0880 for specifics on reporting expenses regarding transportation to and from Day Habilitation.

Units of Service: Report units as per Service Type.

0235 - HCBS Other Than Freestanding Respite

Provision of temporary, short-term relief for families and care providers which enables them to arrange for their vacations, emergency coverage in the event of family or provider illness or death, or for a break from constant, intensive participant care and supervision. This applies only to respite provided in other than a freestanding respite center.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Units of Service: Report using billable units. (i.e.: one quarter hour equals one unit of service.)

0330 - Day Training

A program or planned combination of services provided to developmentally disabled persons whose level of disability is not so severe as to require day treatment services but whose functional behavior deficits limit their ability to function independently. The goal of day training programs is to provide program interventions that will assist developmentally disabled persons in the acquisitions of knowledge and skills that will enable them to improve their personal, social, and vocational skills and their ability to function independently. Day training also includes programs consisting of specialized developmental services that are operated with the goal of providing developmentally disabled persons with habilitation and social skills which will enable the individual to maintain gains made in other programs or to gain entry to a level of programming requiring more independent functioning. The program may operate as a complement to other day programs or on an intermittent basis to accommodate gaps in regular programs. Included here could be afternoon, evening or weekend programs operated by service providers who operate other day services. The emphasis of these programs is on the maintenance of existing skills and the development of social, recreational, and leisure activities which are intellectually and interpersonally

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stimulating and augment health maintenance. This may include recreational, music movement and art activities as indicated in the participant's program plan.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service:

Less than half-day visit: Less than 3 hours = .30

Half-day visit: 3 but less than 5 hours = .50

Full-day visit: 5 hours or more = 1.00

For Budget Format: Count each visit as one visit.

0340 - Certified Work Activity/Sheltered Workshop

A program certified by the U.S. Department of Labor and OPWDD which provides services and experiences to participants with the goal of increasing their economic independence. Work activity programs would tend to emphasize prevocational skills with the objectives of task orientation, coordination skills, and the like with the goal of preparing the individual to function in a sheltered workshop program. Sheltered workshops are for developmentally disabled persons who have the prevocational skills necessary to perform occupational tasks with an acceptable level of output. The goals of such programs are to train individuals in the occupational tasks to be accomplished, provide necessary and appropriate adjustment training and to provide training and experience that will assist the individual in improving his/her performance. An example of this would be a sheltered employment program with the goal of assisting the handicapped person to progress toward competitive employment. The program objective is competitive employment if the potential exists, or long-term employment within a sheltered workshop if competitive employment is not feasible. Program elements would include:

- (a) Diagnostic evaluation and testing;
- (b) Controlled and supervised working experience for training, work adjustments, or employment in conjunction with other services, such as counseling and group therapy; and
- (c) Assessment of progress, referral, and follow-up.

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Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service:

Less than half-day visit: Less than 3 hours = .30

Half day visit: 3 but less than 5 hours = .50

Full-day visit: 5 hours or more = 1.00

0360 - Classroom Education

A program of special education services provided on a consolidated basis with diagnosis and/or rehabilitative services for mentally retarded and developmentally disabled persons between the ages of 5 and 21. Examples of typical services include classroom education for school-aged children; diagnosis and evaluation; instruction in pre-academic skill areas; physical, recreational, and speech and hearing therapy; and counseling of families or other collaterals of participants.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: Each visit.

For Budget Format: Count each visit as one visit.

0370 - Preschool Program

Program which provides services to developmentally disabled individuals under the age of five. The goal of such services is to provide preventive and ameliorative services to children at risk of developmental disability diagnosis in order to prepare them for acceptance into a school program operated by the public schools. The activities of such programs would include but are not limited to pre-academic skills, social interaction skills, self care skills and infant stimulation.

Contract Budget Consistent reporting is required for this program. The same number of columns

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used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: Each visit.

0380 - Transitional Employment

Short term intervention to lead to employment at or above minimum wage. Aimed at individuals who need assistance in learning marketable skills, good work habits and appropriate on-the-job socializing and who can become competitively employed within a time limited period. This takes place in integrated community work settings and emphasizes support provided at the worksite.

Contract Budget consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the Agency Code and the last three digits of the Program Code. Where more than one column will be created for this Program Code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: One hour of service provided to or on behalf of each participant equals one unit of service.

For Budget Format: Count the number of direct hours of service provided to individual participants.

0390 - Supported Employment (Non-HCBS Waiver)

Supported employment is designed for individuals who, because of the severe nature of their disabilities, require ongoing interventions and supports in order to obtain and maintain employment. It is not for those who would be better served in time limited preparations for competitive employment. The individuals must be engaged in meaningful work for wages on a full-time or part-time schedule. The employment must be in an integrated work setting providing frequent daily social interactions with people who are not disabled and who are not paid care givers. Federal guidelines suggest limiting the number of supported employees to eight per site. Supported employment exists only when there is on-going publicly financed support directly related to the maintenance of the supported employment.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more

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than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: For Supported Employment programs that are funded via direct contract, report the direct care units of service. One hour of service provided to or on behalf of each consumer equals one unit of service. Direct care hours/units shall include: hours of pre-employment, hours of on-site intervention, and hours of off-site intervention, as reported on lines 17, 18 and 19 of the Individual’s Quarterly Report. For further clarifications, regarding these categories, refer to the “New York State Interagency Supported Employment Program Instructions for the Individual’s Quarterly Progress”.

For Budget Format: Count the number of direct hours of service provided to individual participants.

0410 - Individualized Support Services

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: As per contract.

0411 - HCBS Consolidated Supports and Services

Only agencies that are designated as a Fiscal Employer/Agent should report under this Program Code.

Program type reporting is required for this program. All expenses paid and revenues claimed by the Fiscal Employer/Agent are to be aggregated and reported in one column. Expenses are reported using all applicable expense line items. Revenue is reported as Medicaid for Medicaid eligible individuals or as “Other Revenue” for non-Medicaid eligible individuals.

The Program/Site Identification Number is created using the first four digits of the agency code and the last three digits of the program code.

Units of Service: One unit of service equals one month.

0413 - HCBS Family Education and Training

HCBS Family Education and Training is training given to the families of consumers enrolled in the Home and Community Based waiver who are under 18 years of age. The purpose of family education and training is to enhance the decision making capacity of the family unit,

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provide orientation regarding the nature and impact of developmental disability upon the consumer and his or her family and teach them about service alternatives. Family education and training is distinct from service coordination in that the purpose is to support the family unit in understanding the coping with the developmental disability. The information and knowledge imparted in family education and training increases the chances of creating a support environment at a home and decreases the chances of a premature residential placement outside the home.

Family education and training is given in a two hour segment twice a year. Sessions may be private or in groups of families. Any personnel knowledgeable in the topics covered may conduct the sessions. Most frequently, this will be service coordinators, but it may also include other clinicians and experts in such fields as the law and finances pertaining to disabilities.

Program type reporting is required for this program. All expenses and revenues for all program sites are to be aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

If the individual receiving the services is HCBS waiver eligible, the funding source is Medicaid. If the individual is not HCBS waiver eligible, the funding is 100% OPWDD funded.

Units of Service: One unit of service equals a minimum of two hours. No more than 2 units of service per eligible person shall be provided on an annual basis to each family.

0414 - Epilepsy Services

Services needed by developmentally disabled individuals with epilepsy to sustain themselves in appropriate community settings. Epilepsy Services typically include, but are not limited to, information and referral, counseling, case management, education and support groups.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: As per contract.

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0415 - HCBS Live-In Caregiver

When a live-in personal caregiver who is unrelated to the individual receiving care provides approved services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the home or residence of the individual served may be reimbursed.

If the individual receiving the services is HCBS waiver eligible, the funding source is Medicaid. If the individual is not HCBS waiver eligible, the funding is 100% OPWDD funded.

Program type reporting is required for this program. All expenses and revenues for all program sites are to be aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Units of Service: One unit of service equals one month.

0416 - HCBS Waiver Plan of Care Support Services

HCBS Waiver Plan of Care Support Services are services needed to review and maintain a current Individualized Service Plan (ISP) for the consumer, and to maintain documentation of the consumer's level of care eligibility.

If the individual receiving the services is HCBS waiver eligible, the funding source is Medicaid. If the individual is not HCBS waiver eligible, the funding is 100% OPWDD funded.

Program type reporting is required for this program. All expenses and revenues for all program sites are to be aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Units of Service: One unit of service equals six months.

0610 - Recreation

A program of social, recreational, and leisure activities which are intellectually and interpersonally stimulating but which are not necessarily part of a goal-based program plan. Agencies which provide no other types of programs should report this service in the recreation category. Recreation activities which are part of other programs should not be reported as part of recreation programs.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

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Units of Service: Each visit.

For Budget Format: Count each visit as one visit.

0630 - Homemaker Services

Services provided in the client's home by a trained person, who is not a member of the household. Services include, but are not limited to, assisting and training the client in home management skills, household tasks, and hygiene skills; and, the training and/or assistance to parents/collaterals in the provision of such services to the developmentally disabled family member.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: Each staff hour.

For Budget Format: Count the total number of homemaker services staff hours.

0670 - Consumer Transportation

The provision of transportation for persons, as specified in the individual service plan, including all necessary supportive services for full and effective integration of the person into community life. The vehicles utilized can be either centrally located, not assigned to a particular program or used exclusively for To/From Day Habilitation.

Service providers who operate their own transportation cost center should report under this program code, as follows:

Revenue: Revenues reported under program code 0670 are to be aggregated and reported in one column.

The only revenues that should be reported under program code 0670 are those revenues received by the reporting agency from billing another agency for the transportation of the other agency's consumers. Transportation revenue included in a rate, fee or price should not be reported under program code 0670. Transportation revenue included in a rate, fee or price should be reported in the appropriate program/site.

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Expense: Expenses reported under program code 0670 are to be aggregated and reported in one column on the appropriate expense lines (Depreciation – Equipment, Interest – Vehicle, etc.) of Schedule CFR-1.

The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

For each program/site operated by your agency for which other than to and from Day Treatment or HCBS Day Habilitation transportation expenses are included in 0670, please report the appropriate allocation of those expenses to that program/site on line 68a of CFR-1. The basis for this allocation must be reasonable and documented. Such allocation methods may include the number of trips or the number of individuals.

For each program/site operated by your agency for which transportation to and from Day Treatment or HCBS Day Habilitation expenses are included in 0670, please report the appropriate allocation of those expenses to that program/site on line 68b of CFR-1. The basis for this allocation must be reasonable and documented. Such allocation methods may include the number of trips or the number of individuals.

Units of Service: One unit of service equals one round trip per person. Note: For one way trips, count two one way trips as one unit of service.

0750 - Information and Referral

The initial process of contacting, interviewing and evaluating persons for the expressed purpose of preliminary determination of the appropriateness of such persons for the receipt of particular services and/or programs including the need for further assessment. Such activities also include the requested imparting of factual knowledge about the availability of particular services, answers to administrative questions, or statements and interpretation of specified clinical data. Included in this category also is the completion and forwarding of written materials that will allow the individual to access or will facilitate access to the appropriate program or service.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: Each staff hour.

For Budget Format: Count the total number of information and referral service staff hours.

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0780 - NYC Housing Resource Consortium

A program that provides guidance to consumers, families of advocates, agencies and BDSO's on the development and implementation of small, individualized living environments in New York City.

0810 - Case Management (Non-Medicaid)

Case management - Activities aimed at linking the patient to the service system and at coordinating the various services in order to achieve a successful outcome. The objective of case management in a mental health system is continuity of care and service. Services may include linking, monitoring and case-specific advocacy.

Linking - The process of referring or transferring a patient to all required internal and external services that include the identification and acquisition of appropriate service resources.

Monitoring - Observation to assure the continuity of service in accordance with the patient's treatment plan.

Case-Specific Advocacy - Interceding on behalf of a patient to assure to services required in the individual service plan. Case management activities are expediting and coordinative in nature rather than the primary treatment services ordinarily provided by the therapist.

Case management services are provided to enrolled patients for whom staff are assigned a continuing case management responsibility. Thus, routine referrals would not be included unless the staff member making the referral retains a continuing active responsibility for the patient throughout the system of service.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service:

Direct staff hours - The number of staff hours spent by staff in providing case management services face-to-face or by telephone directly to patients or collaterals.

Indirect staff hours - The number of staff hours spent by staff in providing case management services on behalf of patients other than face-to-face or by telephone directly with patients or collaterals.

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For Budget Format: Count the total number of staff hours (combine direct and indirect).

0880 - Subcontract Services

This program code is used to report all expenses associated with sub-contract provider agencies for program delivery, and for all revenues received by the reporting agency on behalf of subcontracted provider agencies.

The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Transportation Subcontracts:

For service providers that subcontract for any transportation other than to and from Day Treatment or HCBS Day Habilitation, please report the appropriate allocation of those expenses to that program/site on line 68a of CFR-1. The basis for this allocation must be reasonable and documented. Such allocation methods may include the number of trips or the number of individuals.

For service providers that subcontract for transportation to and from Day Treatment or HCBS Day Habilitation, please report the appropriate allocation of those expenses to that program/site on line 68b of CFR-1. The basis for this allocation must be reasonable and documented. Such allocation methods may include the number of trips or the number of individuals.

Transportation revenue included in a rate, fee or price should not be reported under Program Code 0880. Transportation revenue included in a rate, fee, or price should be reported in the appropriate program/site.

Units of Service:

For transportation, one unit of service equals one round trip per person. Note: For one way trips, count two one way trips as one unit of service.

0890 - Local Governmental Unit (LGU) Administration

The Local Governmental Unit is defined in Article 41 of the Mental Hygiene Law. This program category includes all local government costs related to administering mental hygiene services that are provided by a local government or by a voluntary agency pursuant to a contract with a local governmental unit. LGU Administration is funded cooperatively by OASAS, OMH and/or OPWDD. As such, this program is reported as a shared program on the core schedules (CFR-1 through CFR-6) of the CFR. LGU Administration expenses and revenues related to each State Agency are reported on State Agency specific claiming schedules (DMH-2 and DMH-3).

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Note: This program type is exempt from the Ratio Value allocation of agency administration.

Units of Service: Not applicable.

1053 - Community Residence Part 671 Supportive - Residential Habilitation

Report one aggregated column for all similar services.

Expenses for the following may be included:

- Personal Services
- Vacation Leave
- Mandated Fringe
- Non-mandated Fringe
- Transportation Related
- Staff Travel
- Contracted Direct Care and Clinical Care
- Other OTPS
- Provider Paid Equipment

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the Agency Code and the last three digits of the Program Code. If Program Code 1053 is reported, there must also be one column of Program Code 1054 reported.

Note: Do not include Day Treatment/HCBS Day Habilitation To/From Transportation expense in this program. If a vehicle or staff person is assigned to this program, but is used for to/from transportation, the related expenses must be reported under Program Code 0670. See Program Code 0670 for instructions on reporting and allocating these expenses.

Units of Service: For each unit of service, count one participant day.

1054 - Community Residence Part 671 Supportive - Room and Board

Room and Board. Report one aggregated column for all supportive sites.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. If Program Code 1054 is reported, there must also be one column of Program Code 1053 is reported.

Report only those costs normally occurring in a room and board situation. Additional costs because program participants may have special needs are Res. Hab. costs.

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Note: Do not include Day Treatment/HCBS Day Habilitation To/From Transportation expense in this program. If a vehicle or staff person is assigned to this program, but is used for to/from transportation, the related expenses must be reported under Program Code 0670. See Program Code 0670 for instructions on reporting and allocating these expenses.

Units of Service: For each unit of service, count one participant day.

1090 - Intermediate Care Facility for the Developmentally Disabled (Over 30 Beds)

A facility operated by or subject to certification by the Office for People with Developmental Disabilities with a capacity of over 30 in accordance with the requirements of Part 681 of Title 14 NYCRR and 42 CFR 442. Such facilities provide active programming, room and board, and continuous 24-hour per day supervision. They are located within the population areas of non-developmentally disabled persons. They are not of the facility type known as developmental center or school as defined by Section 13.17 of the Mental Hygiene Law.

If this Program Code is reported, a corresponding OPWDD-1, ICF/DD Schedule of Service, must be completed.

Note: When the ICF/DD rate includes an add-on component for an ICF/DD School contract, report all expense and revenue in a discreet column as program code 3090 or 3091 as appropriate. Add-on for ICF/DD Sheltered Workshop - use program code 2090 or 2091 as appropriate. Add-on for ICF/DD Day Training - use program 5090 or 5091 as appropriate. When the ICF/DD rate includes funding for day program services, report all expense in a discreet column as Program Code 6090, Day Program Services Included in the ICF/DD Reimbursement Rate (On-Site) or Program Code 6091, Day Program Services Included in the ICF/DD Reimbursement Rate (Off-Site). Add-on for VOICF/DD, Day Services Contract – use program code 7090 or 7091 as appropriate.

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the site's Operating Certificate Number as the Program/Site Identification Number.

Note: Do not include Day Treatment/HCBS Day Habilitation To/From Transportation expense in this program. If a vehicle or staff person is assigned to this program, but is used for to/from transportation, the related expenses must be reported under Program Code 0670. See Program Code 0670 for instructions on reporting and allocating these expenses.

Units of Service: For each unit of service, count one participant day.

For Budget Format: Count each participant day as one day.

1091 - Temporary Use Beds (TUBS) in an Intermediate Care Facility (Over 30 Beds)

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When a bed (certified or uncertified) in an ICF/DD (over 30 beds) is used as a temporary use bed, the associated revenues and expenses should be reported under this program code. (Do not report the same revenue and expense under program code 1090 – Intermediate Care Facility (over 30 beds).)

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the site's Operating Certificate Number as the Program/Site Identification Number.

Units of Service: One hour of service equals one unit of service.

1150 - Traumatic Brain Injury (TBI)

Those services which provide individuals with TBI and their families with information, referral, counseling, advocacy, training and emotional support. A professional approach includes intake, follow up documentation and confidentiality. In addition, outreach to schools, hospitals and other human service agencies, as well as, linkage to other professionals through client specific discussion is provided.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Units of Service: As per contract.

For Budget Format: As per contract.

1190 - Special Legislative Grants

Specific grants funded as a result of legislative member support, targeted for a particular purpose.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the Agency Code and the last three digits of the Program Code. Where more than one column will be created for this Program Code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: Not applicable.

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1220 - Care at Home - III

A Medicaid Waiver service providing financial assistance to families with children living at home who have severe disabilities or medical conditions. Parental income and resources are not considered when determining the child's eligibility for Medicaid. Medicaid services include Service Coordination, Respite Care and Assistive Technologies. For care at Home III only: the family must have applied for out-of-home residential placement for the child.

Program type reporting is required for this program. All expenses and revenues for all program sites are to be aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code

Units of Service: Not applicable.

1850 - Voluntary Preservation Project-Formerly Known as Voluntary Operated Maintenance Contract (Also Known as VAAM)

Program type reporting is required for this program. All Program/Site expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the Agency Code and the last three digits of the Program Code. Costs related to Voluntary Preservation Projects may not be included with any other program or site-specific reporting. 100% of Voluntary Preservation Project cost is to be reported as Equipment or Property, as appropriate. If the cost is depreciated on the service provider's books, it will be a reconciling item since 100% of the cost is reported in the first year.

Units of Service: As per contract.

2090 - Voluntary Operated Intermediate Care Facility for the Developmentally Disabled, Sheltered Workshop

Sheltered Workshop services defined as part of the VOICF/DD Active Treatment Plan that are provided to VOICF/DD consumers.

When the service provider operates both the VOICF/DD and the Sheltered Workshop program, the increased portion of the rate and the associated expense are to be reported in this discreet column using the operating certificate number of the VOICF/DD as the program/site identification number. The revenue is reported as Medicaid and the expense is reported using all applicable expense line items. Do not include this revenue and expense in the column used to report the workshop program.

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the ICF/DD's Operating Certificate Number as the Program/Site Identification Number. For each Program Code 2090 column that is reported, there must be a corresponding Program Code 0090 or 1090 column reported

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Units of Service: One day equals one unit of service.

2091 - Voluntary Operated Intermediate Care Facility for the Developmentally Disabled, Sheltered Workshop (Not Operated by Service Provider)

When VOICF/DD consumers attend a Sheltered Workshop program that is not operated by the service provider, the increased portion of the rate and the associated expenses are to be reported in a discreet column under program code 2091 (VOICF/DD, Sheltered Workshop) using the operating certificate number of the ICF/DD as the program/site identification number. Report revenue as “Medicaid” and expense as “OTPS-Other”.

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the ICF/DD’s Operating Certificate Number as the Program/Site Identification Number. For each Program Code 2091 column that is reported, there must be a corresponding Program Code 0090 or 1090 column reported.

Units of Service: One day equals one unit of service.

2190 - Developmental Disabilities Program Council Grants

Specific grants funded by the New York State Developmental Disabilities Program Council, targeted for a particular purpose.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent.

The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: Not applicable.

2220 - Care at Home – IV & VI

A Medicaid Waiver service providing financial assistance to families with children living at home who have severe disabilities or medical conditions. Parental income and resources are not considered when determining the child’s eligibility for Medicaid. Medicaid services include Service Coordination, Respite Care and Assistive Technologies.

Program type reporting is required for this program. All expenses and revenues for all program sites are to be aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the Agency Code and the last three digits of the Program Code.

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Units of Service: Not applicable.

3070 - Shelter Plus Care Housing

A federally-funded program of housing assistance specifically targeted to homeless persons with disabilities and their families. Funds may be used for the payment of rent stipends up to the federally established Fair Market rent, and associated administrative expenses. OPWDD requires any not-for-profit agency in receipt of these funds to report the funds in a separate program column. Shelter Plus Care Grants are made for five or ten years at a time. This program code is used in cases where the federal funds flow through OPWDD.

Units of Service: Not applicable.

For Budget Format: Not applicable.

3090 - Voluntary Operated Intermediate Care Facility for the Developmentally Disabled, School District Contract

If a service provider operates both the School and VOICF/DD programs, VOICF/DD add-on components to the VOICF/DD rate are to be reported as a stand alone program using program code 3090. The educational expenses and revenues relating to the approved private school program should be allocated based on the number of FTE students of the school program. The allocated expenses and revenues should be reported using program code 3090. The revenue is reported as Medicaid and the expense is reported using all applicable expense line items. The expenses and revenues of students served in the approved school program not residing in the ICF will continue to be reported to SED using program code 9000. Refer to program code 3091, if the School and VOICF/DD programs are not operated by the same service provider.

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the ICF/DD's Operating Certificate Number as the Program/Site Identification Number. For each Program Code 3090 column that is reported, there must be a corresponding Program Code 0090 or 1090 column reported.

Units of Service: One ICF residential day equals one unit of service.

3091 - Voluntary Operated Intermediate Care Facility for the Developmentally Disabled, School District Contracts (Not Operated by Service Provider)

Educational services defined as part of the VOICF/DD Active Treatment that are provided to ICF consumers via a contract between the VOICF/DD provider and a local school district. The increase to the VOICF/DD rate that was added for this service and the associated expense is to be reported in this discreet column. Use the operating certificate number of the consumers' ICF as the program/site identification number. The revenue is reported as Medicaid and the expense is reported as "OTPS - Other". When this condition exists in more

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than one VOICF/DD, multiple columns for the VOICF/DD School District Contract will be required.

For each VOICF/DD School District Contract column, there must be a corresponding Program Code 0090 or 1090 column reported.

Units of Service: For VOICF/DD School District Contract, one ICF residential day equals one unit of service.

4090 - State Operated Intermediate Care Facility for the Developmentally Disabled, Sheltered Workshop/Day Training

Sheltered Workshop/Day training services defined as part of the SOICF/DD Active Treatment Plan that are provided to SOICF/DD consumers via a contract. The revenue and the associated expense is to be reported in this discreet column using the operating certificate number of the day training program as the program/site identification number. The revenue is reported as Medicaid and the expense is reported using all applicable expense line items. Do not include this revenue and expense in the column used to report the day training program.

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the Operating Certificate Number of the day training program as the Program/Site Identification Number.

Units of Service: One day equals one unit of service.

5090 - Voluntary Operated Intermediate Care Facility for the Developmentally Disabled, Day Training

Day training services defined as part of the VOICF/DD Active Treatment Plan that are provided to VOICF/DD consumers.

When the service provider operates both the VOICF/DD and the Day Training program, the increased portion of the rate and the associated expense is to be reported in this discreet column using the operating certificate number of the VOICF/DD as the program/site identification number. The revenue is reported as Medicaid and the expense is reported using all applicable expense line items. Do not include this revenue and expense in the column used to report the day training program.

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the ICF/DD's Operating Certificate Number as the Program/Site Identification Number. For each Program Code 5090 column that is reported, there must be a corresponding Program Code 0090 or 1090 column reported.

Units of Service: One day equals one unit of service.

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5091 - Voluntary Operated Intermediate Care Facility for the Developmentally Disabled, Day Training (Not Operated by Service Provider)

When VOICF/DD consumers attend a Day Training program that is not operated by the service provider, the increased portion of the rate and the associated expenses are to be reported in a discreet column under program code 5091 (VOICF/DD, Day Training) using the operating certificate number of the ICF as the program/site identification number. Report revenue as “Medicaid” and expense as “OTPS-Other”.

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the ICF/DD’s Operating Certificate Number as the Program/Site Identification Number. For each Program Code 5091 column that is reported, there must be a corresponding Program Code 0090 or 1090 column reported.

Units of Service: One day equals one unit of service.

6090 - Day Program Services Included in the ICF/DD Reimbursement Rate (On-Site)

Day program services for ICF/DD (Program Code 0090 and 1090) consumers whose comprehensive functional assessments require that such services be delivered by the ICF/DD and the funding for these services is included in the ICF/DD rate.

When an ICF/DD has reimbursement for Day Program Services provided by the ICF/DD included in its rate, the associated expenses of the day program are to be reported in a discreet column under Program Code 6090 using the operating certificate of the ICF/DD as the program/site identification number. The revenue is reported as Medicaid and the expense is reported using all applicable expense line items. Do not report Sheltered Workshop, School District Contract, or Day Training Expenses included in an ICF/DD rate under Program Code 6090. These should be reported using Program Codes 2090, 2091, 3090, 3091, 5090 or 5091.

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the ICF/DD’s Operating Certificate Number as the Program/Site Identification Number. For each Program Code 6090 column that is reported, there must be a corresponding Program Code 0090 or 1090 column reported.

Units of Service:

Half-day service: 3 but less than 5 hours.

Full-day service: 5 hours or more.

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6091 - Day Program Services Included in the ICF/DD Reimbursement Rate (Off-Site)

Day program services for ICF/DD (Program Code 0090 and 1090) consumers whose comprehensive functional assessments require that such services be delivered by other than the ICF/DD and the funding for these services is included in the ICF/DD rate.

When an ICF/DD has reimbursement for Day Program Services provided by other than the ICF/DD included in its rate, the associated expenses of the day program are to be reported in a discreet column under Program Code 6091 using the operating certificate of the ICF/DD as the program/site identification number. Do not report Sheltered Workshop, School District Contract, or Day Training Expenses included in an ICF/DD rate under Program Code 6091. These should be reported using Program Codes 2090, 2091, 3090, 3091, 5090 or 5091. If the service provider operates both the ICF/DD and the day program service, the expense is reported using all expense lines. If the service provider does not operate the day program service, the expense should be reported as “OTPS-Other”. The revenue is reported as Medicaid.

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the ICF/DD's Operating Certificate Number as the Program/Site Identification Number. For each Program Code 6091 column that is reported, there must be a corresponding Program Code 0090 or 1090 column reported.

Units of Service:

Half-day service: 3 but less than 5 hours.

Full-day service: 5 hours or more.

7090 - Voluntary Operated Intermediate Care Facility for the Developmentally Disabled, Day Services Contract

This Program Code should be used when the ICF/DD rate includes an add-on for day programming services where the provider of day program service bills OPWDD directly.

When the service provider operates both the VOICF/DD and the Day Service program, the increased portion of the rate and the associated expense is to be reported in this discreet column using the operating certificate number of the VOICF/DD as the program/site identification number. The revenue is reported as Medicaid and the expense is reported using all applicable expense line items. Do not include this revenue and expense in the column used to report the day service program.

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the ICF/DD's Operating Certificate Number as the Program/Site Identification Number. For each Program Code 7090 column that is reported, there must be a corresponding Program Code 0090 or 1090 column reported.

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Units of Service: Contact during one 24-hour period, regardless of the length of service, equals one unit of service.

7091 - Voluntary Operated Intermediate Care Facility for the Developmentally Disabled, Day Services (Not Operated by Service Provider)

This Program Code should be used when the ICF/DD rate includes an add-on for day programming services where the provider of day program service bills OPWDD directly.

When VOICF/DD consumers attend a Day Service program that is not operated by the service provider, the increased portion of the rate and the associated expenses are to be reported in this discreet column using the operating certificate number of the ICF as the program/site identification number. Report revenue as “Medicaid” and expense as “OTPS-Other”.

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the ICF/DD’s Operating Certificate Number as the Program/Site Identification Number. For each Program Code 7091 column that is reported, there must be a corresponding Program Code 0090 or 1090 column reported.

Units of Service: Contact during one 24-hour period, regardless of the length of service, equals one unit of service.

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Not included in this manual.

Please see the Consolidated Reporting and Claiming Manual (CFR Manual)

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Agency Administration Defined:

Agency administration costs include all the administrative costs that are not directly related to specific programs/sites but are attributable to the overall operation of the agency such as:

- costs for the overall direction of the organization;
- costs for general record keeping, budget and fiscal management;
- costs for governing board activities;
- costs for public relations (*excluding fund raising and special events*); and
- costs for parent agency expenses.

Which may include but are not limited to the following:

- Personal service costs of agency administrative staff (i.e., Executive Director, Comptroller, Personnel Director, etc.)
- Leave accruals and fringe benefits corresponding to the personal services listed above
- Other than personal services costs (OTPS) costs associated with agency administration activities (i.e., telephone, repairs and maintenance, utilities)
- Agency-wide auditing costs for independent licensed or certified public accountants. (Note that agency-wide auditing costs cannot be directly charged as program costs on CFR-1.)
- Depreciation and/or lease costs associated with vehicles and equipment used by agency administration staff.
- Depreciation and/or lease costs associated with space occupied by agency administrative offices.

Agency administration costs do not include fundraising costs and special events costs. Fundraising and special events costs are reported on Schedule 2 in column 7 under “Other Programs”.

Agency administration costs do not include program/site specific costs or program administration costs. Program/site costs are costs directly associated with the provision of services and are included on the appropriate line of expense on Schedules CFR-1 (lines 16 through 63), DMH-1 (lines 6 through 11) and DMH-2 (lines 5 through 10). Program

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administration costs are administrative costs which are directly attributable to a specific program/site (i.e., personal services and fringe benefits of Billing Personnel, Program Director, Program Coordinator, etc.) and are to be included on the appropriate line of expense on CFR-1 (lines 16 through 63), DMH-1 (lines 6 through 11) and DMH-2 (lines 5 through 10). The program administration level of administration may not be applicable to all service providers. However, all service providers must report agency administration.

County operated service providers should note that Local Governmental Unit (LGU) Administration costs are reported as a shared program using program code 0890 on the applicable Schedules CFR-1 through CFR-6 and DMH-1. (Refer to Appendix K.)

Service Providers should note that *all attempts should be made to directly charge an expense* to the appropriate cost center (agency administration or program/site and program administration). If you are unable to direct charge expenses to agency administration or program/site(s) and program administration, the following includes examples of recommended allocation methods:

<i>Expense Item</i>	<i>Recommended Allocation Method</i>
Repairs and Maintenance	Square Footage
Utilities	Square Footage
Staff Travel	Full-Time-Equivalents
Telephone	Number of Lines
Building Depreciation	Square Footage
Building Lease Costs	Square Footage
Mortgage Interest	Square Footage

Property Costs Relating to Agency Administrative Offices:

If agency administrative offices and program offices are located in the same building, property related costs must be allocated using square footage as the statistical basis. These costs include expenses such as utilities, repairs and maintenance, depreciation, leases or mortgage interest. Square footage cost allocations must be calculated using the following procedure (square footage should be the interior square footage):

1. Determine the number of square feet which is used exclusively by agency administrative offices and each program or program/site, not shared in common.
2. Determine the number of square feet which is shared in common, i.e., lobby, restrooms, conference areas, etc.
3. Calculate an allocation ratio by dividing each exclusive square footage amount by the total amount less the commonly shared amount.
4. Multiply each respective cost by the allocation ratios to determine the allocated dollar amount.

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Example: Program A and Agency Administrative Offices occupy the same building. Utility expenses of \$5,000 must be allocated to Program A and to the Agency Administrative Offices as follows:

Step 1 - Exclusive square feet - Program A = 500 sq. ft.
Exclusive square feet - Agency Administrative Offices = 300 sq. ft.

Step 2 - Common Square Feet - 1,000 sq. ft.
Total Square Feet - 1,800 sq. ft.

Step 3 - Program A = $500 / (1,800 - 1,000) = .625$
Agency Administrative Offices = $300 / (1,800 - 1,000) = .375$

Step 4 - Utility Expenses for this particular building total \$5,000

Utility expenses allocated to Program A = $\$5,000 \times .625 = \$3,125$

Utility expenses allocated to Agency Admin. Offices = $\$5,000 \times .375 = \$1,875$

Property related expenses and revenues that do *NOT* pertain to your agency's DMH programs, SED programs and agency administration must be reported in the "Other Programs" column (column 7) of Schedule CFR-2.

Allocation of Total Agency Administration Costs to Program/sites:

To ensure equity of distribution and to provide uniformity in allocation of agency administration, OASAS, OMH, OPWDD, and SED require the *ratio value* (R/V) method of allocation to be used on the core CFR schedules (CFR-1 through CFR-6). The ratio value method uses operating costs as the basis for allocating agency administration expenses. Agency administration expenses must be allocated to programs operated by OASAS, OMH, OPWDD and SED as well as shared programs and "Other Programs" (includes fundraising, special events, management services contracts provided to other entities, all programs funded by non-CFRS participating State agencies, etc.) based upon the ratio of agency administration costs to the service provider's total operating costs. Please refer to Section 9.0 for further information.

The calculation of operating costs and the allocation of agency administration to program/sites is determined on page 2 of Schedule CFR-3. The operating costs used to allocate agency administration operating costs are calculated first on an agency-wide basis and then within each state agency. Operating costs include personal services, leave accruals, fringe benefits and OTPS. Operating costs do not include equipment, property and raw materials.

The agency-wide operating costs (CFR-3, lines 43 through 49) do not include the expenses of programs 0190 and 0890. In determining the operating costs within a state agency, the expenses for certain additional programs are deducted from the agency-wide operating costs. The resulting adjusted operating cost totals are entered on CFR-3, lines 60 through 64.

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Operating expenses for the following programs are to be deducted from agency-wide operating costs (CFR-3, lines 43 through 49):

- For OMH, operating expenses for programs coded 0860, 0870, 1690, 1230, 2980, 6920, 1910, 6910, 0920, 2860, 8810 and programs with an "A" program code index (startup) are deducted from CFR-3, line 44. The adjusted total is entered on CFR-3, line 61.
- For OPWDD, operating expenses for programs coded 2091 and 5091 are deducted from CFR-3, line 45. The adjusted total is entered on CFR-3, line 62.
- For SED, operating expenses for programs coded 9800-9810 are deducted from CFR-3, line 46. The adjusted total is entered on CFR-3, line 63.

The following is an example of how to calculate operating costs, the ratio value factor and the amount of agency administration costs that should be allocated to programs using the ratio value method of allocation.

Provider XYZ reports the following program/site and program administration expenses:

Program	OASAS	OMH	OPWDD	SED	Shared	Other	Total
From Schedule*	CFR-1	CFR-1	CFR-1	CFR-1	CFR-1	CFR-2	
Personal Services	154,000	230,500	840,000	450,000	155,000	60,000	1,889,500
Vacation Accruals	7,700	11,500	4,200	22,500	7,600	3,000	56,500
Fringe Benefits	38,500	57,700	210,000	112,500	38,700	15,000	472,400
OTPS	71,000	185,000	425,000	225,000	63,000	35,000	1,004,000
Equipment	3,200	2,500	7,200	5,900	2,900	1,500	23,200
Property	23,000	18,000	55,000	30,000	27,000	5,800	158,800
Total Before Administration Allocation	297,400	505,200	1,541,400	845,900	294,200	120,300	3,604,400

Provider XYZ reports program/site and program administration expenses for the following OMH programs:

Program	2100	1910	Total
From Schedule*	CFR-1	CFR-1	
Personal Services	230,500	0	230,500
Vacation Accruals	11,500	0	11,500
Fringe Benefits	57,700	0	57,700
OTPS	110,000	40,000	150,000
Operating costs	409,700	40,000	449,700

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For this example, assume page 1 of Schedule CFR-3, Agency Administration, line 42 reflects net agency administration of \$650,400. Net agency administration must be allocated to all programs using the ratio value method which is based on operating costs. Operating costs include personal services, vacation accruals, fringe benefits and OTPS (less sub-contract raw materials - CFR-1, line 29).

Based on the information reported above, operating costs are calculated as follows:

Program	OASAS	OMH	OPWDD	SED	Shared	Other	Total
From Schedule*	CFR-1	CFR-1	CFR-1	CFR-1	CFR-1	CFR-2	
Personal Services	154,000	230,500	840,000	450,000	155,000	60,000	1,889,500
Vacation Accruals	7,700	11,500	4,200	22,500	7,600	3,000	56,500
Fringe Benefits	38,500	57,700	210,000	112,500	38,700	15,000	472,400
OTPS	71,000	185,000	425,000	225,000	63,000	35,000	1,004,000
Operating costs	271,200	484,700	1,479,200	810,000	264,300	113,000	3,422,400

**Abbreviated filers must obtain these amounts from their general ledger.*

The Agency-wide Ratio Value Worksheet on the left hand side of page 2 of Schedule CFR-3 should reflect the information shown below. At the Agency-wide level, program expenses for programs coded 0190 and 0890 are excluded from the operating costs.

<i>Line No.</i>	<i>State Agency</i>	<i>Amount</i>
<i>Calculation of Operating Costs</i>		
43	OASAS Subtotal	271,200
44	OMH Subtotal	484,700
45	OPWDD Subtotal	1,479,200
46	SED Subtotal	810,000
47	Shared Programs Subtotal	264,300
48	Other Programs Subtotal	113,000
49	Total Agency Operating Costs	3,422,400

<i>Line No.</i>	<i>State Agency</i>	<i>Amount</i>
<i>Calculation of Ratio Value Factor</i>		
50	Net Agency Administration (CFR-3, line 42)	495,330
51	Total Agency Operating Costs (CFR-3, line 49)	3,422,400
52	Ratio Value Factor (Line 50 divided by line 51)	.144731

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<i>Line No.</i>	<i>State Agency</i>	<i>Amount</i>
<i>Allocation of Agency Administration Using Ratio Value</i>		
53	OASAS Allocation (line 43 x line 52)	39,251
54	OMH Allocation (line 44 x line 52)	70,151
55	OPWDD Allocation (line 45 x line 52)	214,087
56	SED Allocation (line 46 x line 52)	117,233
57	Shared Programs Allocation (line 47 x line 52)	38,253
58	Other Programs Allocation (line 48 x line 52)	16,355
59	Total Agency Administration (sum lines 53 – 58)	495,330

The Ratio Value Worksheet within State Agency on the right hand side of page 2 of Schedule CFR-3 should reflect the information shown below. To arrive at the adjusted totals, expenses for OMH programs coded 0860, 0870, 1690, 1230, 2980, 6920, 1910, 6910, 0920, 8810 and programs with an "A" program code index (startup) are deducted from CFR-3, line 44. Also, expenses for OPWDD programs coded 2091, 5091, and 7091 are deducted from CFR-3, line 45 and expenses for SED programs coded 9800-9810 are deducted from CFR-3, line 46. In this example, the only additional program that is exempt from the allocation of agency administration within state agency is the OMH is the program coded 1910. The figure shown on line 61 below is calculated as follows: \$484,700 (total operating costs for OMH programs) minus \$75,000 (total operating costs for the program coded 1910) = \$409,700.

<i>Line No.</i>	<i>State Agency</i>	<i>Operating Costs</i>
<i>Calculation of Adjusted Operating Costs</i>		
60	OASAS Adjusted Subtotal	271,200
61	OMH Adjusted Subtotal	409,700
62	OPWDD Adjusted Subtotal	1,479,200
63	SED Adjusted Subtotal	810,000
64	Shared Programs Adjusted Subtotal	264,300
<i>Calculation of Adjusted Ratio Value Factor (transfer to the item description col. Of line CFR-1, line 65)</i>		
65	OASAS Allocation (line 53 divided by line 60)	.144732
66	OMH Allocation (line 54 divided by line 61)	..171227
67	OPWDD Allocation (line 55 divided by line 62)	..144732
68	SED Allocation (line 56 divided by line 63)	..144732
69	Shared Programs Allocation (line 57 divided by line 64)	..144732

The Adjusted Ratio Value Factor calculated on lines 65 through 69 of CFR-3, is transferred to the item description column of CFR-1, line 65. Please note that the Adjusted Ratio Value Factor may be different for each of the state agencies, depending on whether or not the state agency has programs that are exempt from administration at the state agency level.

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To allocate the agency administration expense to program/sites by State agency on CFR-1, line 65, multiply each program/site's total operating costs (reported on line 64 of Schedule CFR-1) by the Adjusted Ratio Value Factor. An amount for agency administration is not entered on CFR-1, line 65, for programs that are exempt from agency administration allocation.

In this example, the three program/sites funded by OMH would be allocated agency administration expenses as follows:

CFR-1 Line #	Expense	OMH 0880 Program	OMH 2100 Program	OMH 4810 Program	Total OMH Programs
16	Personal Services	\$0	\$230,500	\$0	\$230,500
17	Vacation Accruals	0	11,500	0	11,500
20	Fringe Benefits	0	57,700	0	57,700
41	OTPS	35,000	110,000	75,000	185,000
64	Total Operating costs	35,000	409,700	75,000	484,700
65	Agency Administration Allocation (line 64 times .171227	\$0	\$70,151	\$0	\$70,151

Service providers should refer to Section 20 for more specific instructions for claiming agency administration costs.

Note: An agency administration worksheet is available in the NYS CFRS software for Abbreviated and Mini-abbreviated CFR's. Please refer to Appendix T for more information.

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The following guidelines are to be used only after all attempts have been made to direct charge an expense.

These guidelines are for allocating program costs, *exclusive of agency administration*, when a program serves more than one State agency, or when more than one program shares the same item of expense. Examples are given utilizing shared staff, capital and general operating costs as the major categories of expense.

Note: Sheltered Workshop programs shared between Office Mental Health (OMH) and Office for People with Developmental Disabilities (OPWDD) must use units of service for allocating costs.

Shared Staff

Actual hours of service is the preferred statistical basis upon which to allocate salaries and fringe benefits for staff which are jointly shared between State agencies, or work at multiple program/sites. Providers must maintain appropriate documentation reflecting the hours used in this allocation. Acceptable documentation may include payroll records or time studies. SED providers should use the data compiled on Schedule SED-4 to report CFR-4 and CFR-4A information for direct care related service staff. (Refer to Appendix L to determine what constitutes an acceptable time study).

Example 1: Allocation based on hours (the preferred method):

Agency XYZ employs a direct care worker who works at two separate community residences. The standard work week for this person is forty (40) hours. Payroll records indicate 25 hours/week are spent at Site A and 15 hours/week at Site B. This person's salary and fringe benefits are allocated as follows:

$$\begin{aligned} \text{Site A} & - \$22,400 \text{ (annual salary) } \times (25/40) = \$14,000 \\ \text{Site B} & - \$22,400 \text{ (annual salary) } \times (15/40) = \$ 8,400 \end{aligned}$$

Note: the fringe benefit allocation should use the same methodology.

Example 2: Acceptable time study allocation (if the preferred method cannot be utilized):

Agency XYZ employs a social worker who works at two clinic treatment programs. The social worker must maintain a time study to properly allocate time to the proper program (See Appendix L). His/her actual hours worked were not maintained.

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Social Worker Salary: \$25,000

Per time study, the social worker spent 20% of his/her time at Site A and 80% at Site B.

Site A - \$25,000 (annual salary) X 20% = \$5,000

Site B - \$25,000 (annual salary) X 80% = \$20,000

Note: The fringe benefit allocation should use the same methodology.

Example 3: Shared workshop allocation:

Agency XYZ operates a sheltered workshop program which is funded by both OMH and OPWDD. They employ a social worker within this program. The provider determines the number of units of service provided during the cost report period by each funding state agency. (OPWDD = 11,250 units, OMH = 3,750 units) This person's salary is allocated as follows:

OPWDD - \$27,000 (annual salary) X (11,250/15,000)
(units/total units) = \$20,250

OMH - \$27,000 (annual salary) X(3,750/15,000)
(units/total units) = \$6,750

Note: The fringe benefit allocation should use the same methodology.

Capital and Related Costs

Note: If a particular methodology has been specified in the development of the rate/fee, that methodology must be used.

When programs share the same geographic location or more than one State agency is served at the same geographic location, property and related costs must be allocated between the programs/State Agencies benefiting from those resources. These costs include expenses such as utilities, repairs and maintenance, depreciation, leases or mortgage interest. The most common method uses square footage as the statistical basis. However, if the use of this method in a specific situation does not result in a fair allocation of the costs, another reasonable method can be used. Some Square footage cost allocations must be calculated using the following procedure: (square footage should be the interior square footage).

1. Determine the number of square feet which is used exclusively by each program or State agency, i.e., not shared in common.
2. Determine the number of square feet which is shared in common, i.e., lobby, restrooms, conference areas, etc.

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3. Calculate an allocation ratio by dividing each exclusive square footage amount by the total site amount less the commonly shared amount.
4. Multiply each respective cost by the allocation ratios to determine the allocated dollar amount.

Example 1: Square Footage Allocation:

Step 1	Exclusive square feet -	Program A = 500 sq. ft.
	Exclusive square feet -	Program B = 300 sq. ft.
Step 2	Common Square Feet	- 1,000 sq. ft.
	Total Site Square Feet	- 1,800 sq. ft.
Step 3	Program A = $500 / (1,800 - 1,000)$	= .625
	Program B = $300 / (1,800 - 1,000)$	= .375
Step 4	Program A Allocation = $\$5,000 \times .625$	= \$3,125
	Program B Allocation = $\$5,000 \times .375$	= \$1,875

One reason why the square footage might not accurately reflect the cost to be allocated to a State Agency/Program would occur when a program uses a significant amount of space, but not much space exclusively. In that case, units of service or staff FTEs might be a better choice as the basis for the allocation. In a case where the shared space is used at different times by different programs (daytime vs. evening, different days) the hours of use might better reflect the benefit to the program and the allocation of the costs.

To expand on the example above, assume program A uses the common area 3 days per week and program B uses the common area 2 days per week:

Step 1	Exclusive square feet -	Program A = 500 sq. ft.
	Exclusive square feet -	Program B = 300 sq. ft.
Step 2	Common Square Feet	- 1,000 sq. ft.
	Total Site Square Feet	- 1,800 sq. ft.
Step 3	Program A = $500 + (3/5 * 1000) / 1,800$	= .61111
	Program B = $300 + (2/5 * 1000) / 1,800$	= .38889
Step 4	Utility Expenses =	\$5,000
	Program A Allocation = $\$5,000 \times .61111$	= \$3,056
	Program B Allocation = $\$5,000 \times .38889$	= \$1,944

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Any questions should be referred to the funding state agencies or your accounting professional.

If all space is shared in common, then the allocation ratio should be calculated based upon the full units of service provided in each program or State Agency to the total full units of service provided at the location.

Example 2: Units of Service Allocation :

: A workshop program serves both OMH and OPWDD participants. The space used is common to both State agencies. Therefore, the following allocation basis is utilized:

OMH Full Units of Service = 50	50/150 = .3333
OPWDD Full Units of Service = 100	100/150 = .6667
Total Full Units of Service = 150	150 = 1.000
Rent Expense: \$10,000	
OMH = \$10,000 X .3333 = \$3,333	
OPWDD = \$10,000 X .6667 = \$6,667	

General Operating Expense

Expenses such as food, transportation, supplies and material, staff travel and training, etc. which cannot be directly charged to a specific program or State agency must be allocated across all such entities deriving benefits. If you are unable to direct charge expenses to agency administration or program/site(s), you may use the following recommended allocation methods for each specific OTPS item:

OTPS Item	Recommended Allocation Method
Food	Meals Served
Repairs and Maintenance	Square Feet
Utilities	Square Feet
Transportation Related	Number of Trips or Mileage
Staff Travel	Full-Time-Equivalents
Participant Incidentals	Direct Charge Only
Expensed Equipment	Units of Service if the item is shared by more than one State agency or program site.
Subcontract Raw Materials	Direct Charge Only
Participant Wages	Direct Charge Only
Staff Development	Full-Time-Equivalents
Supplies and Materials	Units of Service
Telephone	Number of Lines
Insurance-General	Ratio Value
Other	Units of Service

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If the recommended allocation method does not apply, the provider should determine a more reasonable method of allocation. Example: A service provider needs to allocate supplies and materials costs to several program/sites. The recommended allocation method noted above is units of service. However, all the program/sites do not report units of service. In this case, a more reasonable method of allocating supplies and materials would be to allocate the cost based on usage.

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Local Governmental Unit Administration (LGU) is considered a unique cost center over and above the cost to the agency as a service provider; therefore, a separate cost center should be maintained for LGU administration detailing personal services and other than personal services costs. LGU administration costs are required to be reported as a shared program (program code 0890) on the core CFR schedules (CFR-1 through CFR-6) and DMH-1. The journal entries should be made during the provider's normal accounting cycle. The following is a partial list of activities from Section 41.13 of the Mental Hygiene Law (MHL) which are associated with the responsibility of the LGU. Refer to the MHL for a complete description.

- Review services and local facilities for the mentally disabled of the area which it serves and their relationship to local need; determine needs of the mentally disabled of such area; and encourage programs of prevention, diagnosis, care, treatment, social and vocational rehabilitation, special education and training, consultation, and public education on mental disabilities.
- Develop a program of local services for the area which it serves, establish long-range goals of the local government in its programs for the mentally disabled, and develop intermediate range plans and forecasts, listing priorities and estimated costs.
- Direct and administer the development of a local comprehensive plan for all services for mentally disabled residents of the area, which shall be submitted to the department and used in part to formulate a statewide comprehensive plan for services.
- Seek to assure that under the goals and plans required, all population groups are adequately covered, sufficient services are available for all the mentally disabled within its purview, that there is coordination and cooperation among local providers of services, that the local program is integrated and coordinated with the programs of the department, and that there is continuity of care among all providers of services.
- Submit annually to the department for its approval and subsequent State Aid, a report of long-range goals and specific intermediate range plans as modified since the preceding report, along with a local services plan or unified services plan for the next fiscal year.
- Have the power, with the approval of local government, to enter into contracts for the provision of services and the construction of facilities including contracts executed pursuant to subdivision (e) of section 41.19 of this article and the power, when necessary, to approve construction projects.
- Establish procedures for execution of local government, to enter into contracts for the provision of services and the construction of facilities including regulations to guide the provision of services by all organizations and individuals within its program.

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- Make policy for and exercise general supervisory authority over or administer local services and facilities provided or supervised by it whether directly or through agreements, including responsibility for the proper performance of the services provided by other facilities of local government and by voluntary and private facilities which have been incorporated into its comprehensive program. Serve as a center for the promotion of community and public understanding of mental disabilities and of the services necessary for their care and treatment.
- Seek the cooperation and cooperate with other public health and social services agencies, public and private, in advancing the program of local or unified services.
- Further programs for special education and training, including career incentive and manpower and development.
- Have the power to conduct or contract for such research as may be useful for the discharge of its administrative duties and for the promotion of scientific knowledge of the mental disabilities.
- Have the powers necessary and proper for the effective performance of its functions and duties.
- Require the development of a written treatment plan as provided in rules and regulations of the commissioner.

The preceding list should enable a service provider to determine between agency administration functions (e.g., executive director) and LGU functions.

A separate cost center should be set up for LGU administration on the LGU's general ledger. If this is not feasible, the following procedures must occur:

Personal Services

First, determine all personnel who spent 100% of their time on LGU administration.

For personnel who spent less than 100% of their time on LGU, a time study must be performed to properly allocate their time (refer to the guidelines for an acceptable time study in Appendix L).

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Fringe Benefits

Applicable fringe benefits to employees who are working in LGU administration should be detailed as follows:

Example:

i.	Fringe Benefits	\$150,000
ii.	Total Personal Services	1,500,000
iii.	Fringe Benefit Percentage (line i, line ii)	.10
iv.	Joe Smith's Salary	50,000
v.	Fringe Benefits Applicable to Joe Smith (line iii x line iv)	5,000
vi.	Percentage of Time Related to LGU	10%
vii.	Personal Service Cost Related to LGU (line iv x line vi)	5,000
viii.	Fringe Benefits Applicable to LGU (line v x line vi)	500

Other Than Personal Services

First, determine if the cost related to LGU administration can be identified separately. The cost would include:

Professional Fees - Auditing and Accounting, Payroll Processing, Corporate Legal & Management Consulting, Investment Counseling, Public Relations and Advertising.

Employment Recruiting - Help Wanted Advertising, Employment Agency Fees, Costs of Temporary Office Help.

Supplies - General Supplies, Postage and Shipping Charges, EDP Software and Supplies, Cleaning and Maintenance Supplies.

Travel - Airfare, Train, Program Vehicle Operating Expenses (Insurance Registration, Fuel, Repairs), Conferences/Convention Costs for Program Staff.

Equipment - Depreciation, Interest, Lease Expenses for Fixed Major Moveable and Minor Equipment, Repair and Maintenance Expenses of Equipment.

Property - Repairs and Maintenance, Insurance, Taxes, Utilities, Rental/Lease, Depreciation Building Improvement, Leasehold Expenses and Improvements, Mortgage Interest (do not include principal amounts).

Other - Other expenses related to the administration of the program not reported above. These should be reported by item of expense.

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Service providers may be requested to submit the County Wide Cost Allocation Plan. This plan is prepared and certified by an independent, licensed or certified public accountant. This plan must include a listing of the type of service, amount and allocation base.

If LGU other than personal service costs are included with agency administration because the employee is only working a portion of their time on LGU administration, the following approach is required:

Determine the total amount of LGU personal service and fringe benefit costs; then divide that amount by the sum of your agency administration and LGU personal service and fringe benefits cost to determine the percent of LGU personal service and fringe benefits related to LGU administration. This percentage would be multiplied times other than personal service cost (e.g., OTPS, equipment and property cost) related to agency administration to determine total other than personal service cost related to LGU administration.

Example:

1.	Total LGU personal service and fringe benefits	\$120,000
2.	Total agency administration and LGU personal services and fringe benefits (includes LGU)	450,000
3.	Percentage of LGU personal service and fringe benefit cost to total agency administration and LGU (line 1, line 2)	.2667
4.	Total agency administration and LGU OTPS costs	525,000
5.	Portion of OTPS cost related to LGU administration (line 3 x line 4)	140,018
6.	Total agency administration and LGU equipment cost	25,000
7.	Portion of equipment cost related to LGU administration (line 3 x line 6)	6,668
8.	Total agency administration and LGU property cost	120,000
9.	Portion of property cost related to LGU administration (line 3 x line 8)	32,004
10.	<i>Total cost related to LGU Administration cost (lines 1, 5, 7 and 9)</i>	<i>\$298,690</i>

Please refer to Volume XI, Section 6.04 (Special Payments – Municipal Overhead Costs) of the New York State Accounting System User Procedures for more clarification on the reimbursement of LGU administration costs. (A copy of Section 6.04 can be found on page 35.9.)

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Following is a listing of the allocated percentages between the DMH agencies for all counties for the LGU administration expenses and revenues. These should be used when preparing your budgets and claims.

*Department Of Mental Hygiene
County Administration Percentage Splits as Calculated In 1988*

Counties		OASAS Percentage	OMH Percentage	OPWDD Percentage	Total 620/REG as % of Total
Albany	Total	37.49	36.09	26.42	100.00
	620			100.00	4.33
	OT620	39.19	37.72	23.09	95.67
Allegany	Total	29.30	24.08	46.62	100.00
	620				0
	OT620				100.00
Broome	Total	26.77	28.37	44.86	100.00
	620				0
	OT620				100.00
Cattaraugus	Total	8.74	16.61	74.65	100.00
	620				0
	OT620				100.00
Cayuga	Total	.89	14.50	84.61	100.00
	620				0
	OT620				100.00
Chautauqua	Total	51.90	48.10	0	100.00
	620				0
	OT620				100.00
Chemung	Total	17.53	32.79	49.68	100.00
	620			100.00	9.34
	OT620	19.33	36.18	44.49	90.66
Chenango	Total	7.88	21.57	70.55	100.00
	620				0
	OT620				100.00
Clinton	Total	7.32	41.95	50.73	100.00
	620			100.00	9.90
	OT620	8.12	46.56	45.32	90.10
Columbia	Total	6.00	20.00	74.00	100.00
	620		0	100.00	37.00
	OT620	9.52	31.75	58.73	63.00
Cortland	Total	21.13	29.36	49.51	100.00
	620				0
	OT620				100.00

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Counties		OASAS Percentage	OMH Percentage	OPWDD Percentage	Total 620/REG as % of Total
Delaware	Total	13.14	14.07	72.79	100.00
	620			100.00	25.70
Dutchess	OT620	17.68	18.94	63.38	74.30
	Total	17.40	40.00	42.60	100.00
Erie	620		0	100.00	18.75
	OT620	21.41	49.22	29.37	81.25
Essex	Total	30.55	51.64	17.81*	100.00
	620			100.00	8.66
Franklin	OT620	33.44	56.54	10.02	91.34
	Total	20.44	20.82	58.74	100.00
Fulton	620				0
	OT620				100.00
Genesee	Total	9.55	11.50	78.95	100.00
	620				0
Greene	OT620				100.00
	Total	34.06	57.40	8.54	100.00
Hamilton	620				0
	OT620				100.00
Herkimer	Total	19.19	33.82	46.99	100.00
	620				0
Jefferson	OT620				100.00
	Total	6.12	31.76	62.12	100.00
Lewis	620			100.00	1.83
	OT620	6.24	32.35	61.41	98.17
Livingston	Total	34.68	38.16	27.16	100.00
	620				0
Livingston	OT620				100.00
	Total	39.02	57.76	3.22	100.00
Livingston	620				0
	OT620				100.00
Livingston	Total	22.70	72.21	5.09	100.00
	620				0
Livingston	OT620				100.00
	Total	9.33	27.06	63.61	100.00
Livingston	620				0
	OT620				100.00
Livingston	Total	100.00	0	0	100.00
	620	0	0	0	0

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Counties		OASAS Percentage	OMH Percentage	OPWDD Percentage	Total 620/REG as % of Total
	OT620	100.00	0	0	100.00
Madison	Total	14.80	21.66	63.54	100.00
	620 OT620				0 100.00
Monroe	Total	0	73.34	26.66	100.00
	620	0	0	100.00	2.58
	OT620	0	75.28	24.72	97.42
Montgomery	Total	41.61	58.39	0	100.00
	620 OT620				0 100.00
Nassau	Total	0	92.90	7.10	100.00
	620 OT620				0 100.00
Niagara	Total	22.12	56.09	21.79	100.00
	620 OT620				0 100.00
Oneida	Total	23.82	25.91	50.27	100.00
	620 OT620				0 100.00
Onondaga	Total	24.44	36.59	38.97	100.00
	620			100.00	11.46
	OT620	27.61	41.32	31.07	88.54
Ontario	Total	9.85	32.45	57.70	100.00
	620 OT620				0 100.00
Orange	Total	14.99	46.41	38.60	100.00
	620			100.00	12.50
	OT620	16.87	52.21	30.92	87.50
Orleans	Total	13.95	14.02	72.03	100.00
	620 OT620				0 100.00
Oswego	Total	4.05	44.10	51.85	100.00
	620 OT620				0 100.00
Otsego	Total	12.72	16.01	71.27	100.00
	620 OT620				0 100.00
Putnam	Total	16.37	57.71	25.92	100.00

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Counties		OASAS Percentage	OMH Percentage	OPWDD Percentage	Total 620/REG as % of Total
	620				0
	OT620				100.00
Rensselaer	Total	10.25	55.23	34.52	100.00
	620				0
	OT620				100.00
Rockland	Total	13.56	56.62	29.82	100.00
	620			100.00	9.30
	OT620	14.95	62.43	22.62	90.70
St. Lawrence	Total	58.55	27.08	14.37	100.00
	620				0
	OT620				100.00
Saratoga	Total	20.67	30.64	48.69	100.00
	620				0
	OT620				100.00
Schenectady	Total	19.20	17.90	62.90	100.00
	620				0
	OT620				100.00
Schoharie	Total	18.92	15.89	65.19	100.00
	620				0
	OT620				100.00
Schuyler	Total	22.81	25.10	52.09	100.00
	620				0
	OT620				100.00
Seneca	Total	19.93	38.14	41.93	100.00
	620				0
	OT620				100.00
Steuben	Total	39.84	20.37	39.79	100.00
	620				0
	OT620				100.00
Suffolk	Total	**	68.71	31.29	100.00.
	620			100.00	72
	OT620		69.20	30.80	99.28
Sullivan	Total	20.03	32.6034.30	47.37	100.00
	620			100.00	4.95
	OT620	21.07		44.63	95.05
Tioga	Total	9.21	42.34	48.45	100.00
	620				0

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Counties		OASAS Percentage	OMH Percentage	OPWDD Percentage	Total 620/REG as % of Total
	OT620				100.00
Tompkins	Total 620	10.49	26.81	62.70	100.00
	OT620				0
Ulster	Total 620	12.63	42.84	44.53	100.00
	OT620	15.94	54.09	29.97	20.80
Warren	Total 620	7.50	52.90	39.60	100.00
	OT620				0
Washington	Total 620	8.40	58.10	33.50	100.00
	OT620				0
Wayne	Total 620	28.74	12.34	58.92	100.00
	OT620				0
Westchester	Total 620	11.34	69.53	19.13	100.00
	OT620	11.57	70.90	17.53	1.94
Wyoming	Total 620	36.53	63.47	0	100.00
	OT620				0
Yates	Total 620	0	33.83	66.17	100.00
	OT620				0

** Methodology exception for Chapter 620, actual expenditures for Chapter 620.*

***Currently, separate OASAS administration may be changing back to Health Services.*

The following is from the New York State Office of the State Comptroller and can be found in Volume XI, Section 6.04 (Special Payments – Municipal Overhead Costs) of the New York State Accounting System User Procedures Manual.

The Federal Office of Management and Budget's Circular A-87 revised as of May 10, 2004 established standards for reimbursing state and local governments for overhead costs incurred in administering Federally funded programs. The principle set forth in the circular is that the Federal government should reimburse

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state and local governments for the total costs of administering Federal programs, except where restricted or prohibited by law.

In the case of local governments, the circular applies only to overhead cost reimbursements to the locality by the Federal government, It does not apply to State-financed programs and does not obligate the State to change any of its policies regarding reimbursements to localities for State-aided programs, For example, such local administrative costs as legal services, personnel, budgeting, accounting, chief executives office, etc, are not automatically eligible for State aid,

Local administrative costs may be eligible for State aid reimbursement subject to the following conditions which have been agreed to by OSC and the State Division of the Budget. The conditions are:

- 1. Payment for these costs cannot be made unless they were contemplated in the program costs set forth in the State's Executive Budget and approved by the State Legislature,*
- 2. The extent to which the State may want to participate in a particular-program will depend upon the availability of funds in the light of other priorities. Therefore, the addition of central staff overhead may result in a decision to lower the percentage contribution by the State.*

New York State Consolidated Budget and Claiming Manual	Subject: Appendix L – Acceptable Time Studies	Section/Page: 36.1
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All personnel who work in more than one program should allocate their salary to the proper cost center during the normal accounting cycle based on actual time and attendance records. If this does not occur, the service provider must complete a time study for each employee who works in more than one program. Following are criteria for an acceptable time study. These criteria are the minimum standards. If necessary, a service provider can expand the length of the time study.

- A minimally acceptable time study must encompass at least two weeks per quarter of the cost reporting period.
- Each week selected must be a full week (Monday to Friday, Monday to Saturday, or Sunday to Saturday).
- The weeks selected must be equally distributed among the months of the cost reporting period, e.g., week 3 and 4 in March, week 2 and 3 in June, week 3 and 4 in September, and week 1 and 2 in December.
- No two consecutive quarters may use the same weeks for the study, e.g., week 1 and 2 in March and June.
- The time study must be contemporaneous with the costs to be allocated. Thus, a time study conducted in the current cost reporting year may not be used to allocate the costs of prior or subsequent cost reporting years.
- The time study must be provider specific.

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This Appendix is not applicable for Office of Mental Health (OMH), Office for People with Developmental Disabilities (OPWDD) and State Education Department (SED). OMH providers should refer to Part 587 and 588 of New York State Codes, Rules and Regulations.

The following rules have been established to reduce variation in service volumes due to inter-facility differences in organizational structure, operational interpretation of definitions, counting procedures and criteria for admitting family members. Relevant definitions follow this section.

The rules below apply to statistical reporting. Rules for billing Medicaid and most other third-party payors are more restrictive.

The following rules for counting visits apply to each program/site of the service provider.

- Rule 1.* A person (participant, client, collateral or significant other) can have no more than one full visit to a given program in a day (midnight to midnight).
- Rule 2.* A person can have a community residence day and, in addition, a visit to a non-residential program in the same day.
- Rule 3.* No combination of visits may add up to more than one full day visit. For example, a participant may have up to two half day visits to a program, but not a full day visit and another kind of visit.
- Rule 4.* When a participant attends a given program, then leaves and returns for a second attendance in the same day, the time of the two (or more) attendances must be cumulated and the visit reported as a single visit to that program.
- Rule 5.* If a client/participant and collateral or significant other are seen the same day, separate visits may be counted provided:
 - 1. The collateral or significant other participates actively in the program and does not merely accompany or wait for the patient.
 - 2. The collateral or significant other's participation is adequately documented in facility/unit records.
- Rule 6.* Only one visit to a program may be reported even when the participant receives more than one procedure or service or is served by more than one staff member or discipline during a visit.
- Rule 7.* Except for pre-admission screening, a participant and collateral or significant other visit may not be counted unless the patient is on the facility/unit rolls.

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Rule 8. A visit is a face-to-face contact between a participant and a clinician whether singularly or in a group. For a group session, therefore, each individual should be counted as having a visit.

New York State Consolidated Budget and Claiming Manual	Subject: Appendix N – DMH Funding Codes and Funding Code Indexes	Section/Page: 38.1
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The following is a listing of the funding source codes to be used on Schedule Department of Mental Health (DMH)-3 by all DMH providers. Office of Mental Health (OMH) only index codes and OMH only Community Reinvestment codes are also listed.

*Note: Office of Alcoholism and Substance Abuse Services (OASAS) providers must indicate the source of funds (S, J, M, F, C, P) consistent with their most recent approved budget in the funding source code index field.

DMH Code #	OMH Only Index	Description
001		<p>Local Assistance - Regular State/Federal - (OMH, OPWDD) (Article 41, Section 18(b), Title E, MHL). Local governments are granted State Aid for approved net operating costs pursuant to an approved local services plan at the rate of 50% of the amount incurred during the local fiscal year by the local governments and volunteer agencies pursuant to a contract.</p> <p>Unified Services Plan Financing - (OMH, OPWDD) (Article 41, Section 23(a)(b)(c)(d), Title E, MHL). Aggregate costs incurred pursuant to an approved unified services plan are funded according to provisions in Section 23. (See Section G DMH-2 for unified services rates).</p> <p>OMH service providers using funding source code 001 must also indicate the funding source index in the funding source code index field on DMH-3.</p>
001	A	Adults - (OMH Only)
004		Chapter 620 - (OPWDD) (Article 41, Section 18(b), Title E, MHL) Local governments having a contract to provide services to persons who were patients in a State facility for a period of five or more years following January 1, 1969 are granted State Aid at the rate of 100% of approved net operating expenses.
005		Chapter 620 Direct Contract - (OPWDD) (Article 41, Section 18(b), Title E, MHL) Voluntary agencies having direct contracts with an office of the department to provide Chapter 620 services are granted State Aid at the rate of 100% of approved net operating expenses.
013		Continual 100% Net Deficit - State/Federal - (OASAS) State Aid may be provided to local governments and to voluntary agencies in an amount up to 100% of the approved net operating cost for the delivery of jointly certified residential services to chemically dependent youth, certified community residential beds, certified alcoholism crisis services and innovative treatment and prevention programs pursuant to legislation and approved local services or unified services plans.

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DMH Code #	OMH Only Index	Description
014		Community Support Services - (OMH) The CSS program provides a variety of outpatient mental health services to the seriously and persistently mentally ill who meet CSS eligibility requirements. The program is operated through approval letters with counties and direct contracts between OMH and voluntary agencies. Approved costs are funded at the rate of 100% State participation.
020		Direct Sheltered Workshop - (OMH, OPWDD) (Article 41, Section 39, Title E, Mental Hygiene Law). Voluntary not-for-profit agencies who receive income through the operation of a sheltered workshop or industrial contract may have that income matched dollar-for-dollar through direct contract. However, eligibility for this assistance requires that no part of the expenses of the workshop be claimed through a contract with the local governmental unit. No combination of income including State Aid can exceed the total cost of operation of the workshop.
021		Direct Local Assistance - (OMH, OPWDD) (Article 41, Section 13(e), Title E, Mental Hygiene Law). Voluntary agencies having direct contracts with an office/division of the department are granted State Aid for approved net operating costs for services provided in accordance with an applicable local services plan at the rate of 50% of the amount incurred during the local fiscal year.
022		Day Training Projects - (OPWDD)
024		SOICF Day Training - (OPWDD) Agencies are provided State Aid up to 100% of the net operating costs related to the provision of SOICF Day Training services to SOICF services consumers.
029		Special Legislative Grants - (OPWDD only) (Article 41, Section 37, Title E, Mental Hygiene Law). Self-explanatory.

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DMH Code #	OMH Only Index	Description
031		<p>Program Development Grants - (OMH, OPWDD) (Article 41, Section 37, Title E, Mental Hygiene Law). Local governmental units and voluntary not-for-profit agencies are eligible for grants for up to 100% reimbursement for development costs of a community residence or residential treatment facility (RTF) incurred prior to the operation of the community residence or RTF. These costs may include:</p> <ul style="list-style-type: none"> - Reasonable legal and other professional fees; - Initial staffing; - Up to six months rent; - Furniture; - Reasonable rehabilitation costs. <p>OMH service providers using funding source code 031 must also indicate the funding source index in the funding source code index field on DMH-3.</p>
031	B	Community Residence - Children (OMH Only)
031	C	New York/New York (OMH Only)
031	F	2000 Capital Bed Plan (OMH Only)
031	G	New York/New York III PDG
034	J	Adult Case Management (OMH Only) – Funding for the following programs: Assertive Community Treatment, Adult Home Supportive Case Management, Intensive Case Management, Supportive Case Management, Blended Case Management, Non-Medicaid Care Coordination and Service Dollars related to these program types.
034	K	Children’s Case Management (OMH Only) – Funding for the following programs: Residential Treatment Facility Transition Coordinators, Intensive Case Management, Supportive Case Management, Blended Case Management, Non-Medicaid Care Coordination and Service Dollars related to these program types.
036		Comprehensive Psychiatric Emergency Program - (OMH). Article 28 General Hospitals are eligible for funding at the rate of 100% of approved net operating costs for providing complete crisis response system of crisis intervention, crisis outreach and crisis residence.
037		Ongoing Integrated Supported Employment Services – (OMH Only) - These funds are intended for ongoing job maintenance services including job coaching, employer consultation, and other relevant supports needed to assist an individual in maintaining a job placement.

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DMH Code #	OMH Only Index	Description
037	A	A Peer Support/Psych. Rehab. – (OMH Only) – For 100% of net operating expenses incurred for approved new or expanded Peer Support and/or Rehabilitation programs.
037	P	Personalized Recovery Oriented Services (PROS) - (OMH Only)
039	A	Legislative Special – Assembly Items (OMH Only)
039	C	MICA - (OMH Only)
039	D	Legislative Special Contracts– Senate (OMH Only) – 100%
039	G	Adult Family Support - (OMH Only)
039	J	Forensics - (OMH Only)
039	L	Psychiatric Rehabilitation - (OMH Only)
039	M	Support Services to Consumers - (OMH Only)
039	P	Clinical Infrastructure – Adult (OMH Only)
039	Q	Innovative Psychiatric Rehab – (OMH Only)
039	V	Legislative Special – Governor (OMH Only) 100% State Funded
039	Z	Psychiatric Center Rent - Adult (OMH Only) effective 1/1/96.
040		Demonstration Grants - (OPWDD) (Article 41, Section 35, Title E, Mental Hygiene Law). The Commissioners of DMH may develop plans for three or more time limited demonstration programs, the purpose of which is to test and evaluate new methods or arrangements for organizing, financing, staffing and providing services for the mentally disabled in order to determine the desirability of such methods or arrangements. The demonstration programs required to be developed include at least one single system program for comprehensive services for OPWDD clients to be provided by local governments. The local government units receive grants from the department not to exceed 75% of net operating costs.
041		Federal Community Mental Health Services Block Grant Funds - Adult - (OMH).
042		Medicaid Infrastructure Grant – (OMH Only) These funds support the improvement of competitive employment opportunities for people with disabilities.
044		Federal Community Mental Health Services Block Grant Funds – C+F - (OMH).
046		Children and Families Program Grants - (OMH). For 100% of the net operating expenses incurred by local governments and voluntary providers in support of mental health programs for children and families (General and Special Revenue Funds).
046	A	Clinical Infrastructure – Children and Families – (OMH Only)
046	C	Coordinated Children's Services Initiatives - (OMH Only)
046	G	Emergency Services – (OMH Only)

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DMH Code #	OMH Only Index	Description
046	L	C & F Community Support Programs - (OMH Only)
046	M	Mott Haven System of Care - (OMH Only)
046	N	Child & Family Clinic Plus (State Aid)
046	P	Child & Family Telepsychiatry (State Aid)
046	S	School Support Services - (OMH Only)
048	A	Homeless MI (PATH) - (OMH Only)
048	C	New York/New York (PATH) - (OMH Only)
049	B	Federal HUD Shelter Plus Care - (OMH Only) where funds flow through OMH only. Other cases, use code 062.
053		Road to Recovery – (OASAS Only)
057		Supportive Work - (OPWDD) Agencies are provided State Aid up to 100% of the net operating cost to enhance the continuum of day programming services in order to serve underserved persons over the age of 21, including the aging out and other individuals living at home.
058		Family Support Services Funding - (OPWDD). Agencies are provided State Aid up to 100% of the net operating costs related to the provision of family support services including but not limited to the following: respite, crisis intervention, family support training and counseling, home modification, transportation, recreation and special adaptive equipment.
059		M.R. Crisis Intervention - (OPWDD) 100%.
062		Federal HUD Shelter Plus Care – (OMH Only) 100% - Includes funds that do not flow through OMH; non-OMH funds only.
072	A	Adult Community Residence Operating - (OMH Only)
072	B	Children CR Operating - (OMH Only)
072	C	Single Room Occupancy - (OMH Only) - Single Room Occupancy (SRO) NY/NY I.
072	D	RCCA Operating - (OMH Only)
072	E	NY/NY 2 Operating - (OMH Only)
072	F	2000 Capital Bed Plan – Operating
072	G	New York/New York III Operating
072	T	Community Residence Operating Costs for Former Transitional Care Individuals - (OMH Only)
073	A	Adult Community Residence Property - (OMH Only)
073	B	Children CR Property - (OMH Only)
073	C	New York/New York Property - (OMH Only)
073	D	RCCA Property - (OMH Only)
073	E	NY/NY 2 Property - (OMH Only)
073	F	2000 Capital Bed Plan Property

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DMH Code #	OMH Only Index	Description
073	G	New York/New York III Property
073	T	Community Residence Property Costs for Former Transitional Care Individuals - (OMH Only)
074		Family Based Treatment - (OMH). State Aid is provided to cover 100% of net cost.
076		Residential Treatment Facilities - (OMH) OMH will fund the State share of Medicaid cost of the residential care program incurred by children placed in these facilities.
078		Independent Apartment/Supported Housing - (OMH) 100% funding will be provided to not-for-profit agencies to locate and furnish housing for clients transitioning from CR programs to independent living. Funding will also be provided for client placement and follow up services.
078	G	New York/New York III Supported Housing
078	Z	Single Room Occupancy (SRO) (OMH Only) - housing related to the 99/00 housing add
080		Homemaker Funds - (OPWDD) Homemaker funds are provided through contractual arrangements with agencies, individuals and families to provide parent respite, home management, client training, and emergency assistance.
089		Individual Support Services/HCBS Consolidated Supports and Services - (OPWDD) 100%
090		Non-Funded - The non-funded category is used to balance the funding for programs that are outside the jurisdiction of DMH and/or program costs which are ineligible for state participation. Please note that gross expenses cannot have a negative balance.
091	A	Federal SAMHSA (NYC Providers only) – OMH Only.
091	C	Federal Community Development Block Grant (Drop In Centers) (NYC Providers Only) – OMH Only.
091	D	Federal HOPWA (NYC Providers only) – OMH Only.
091	E	Emergency Shelter Grant (NYC Providers only) – OMH Only.
096	A	Community Based Family Care General - (OMH) 100% State funded.
096	K	Home and Community-Based Services Waiver – General Fund (OMH Only).
111		Federal Drug Free Schools & Communities Act - (OMH C&F Community Support Program) - 100%
122		Community Support Programs - Misc (OMH Only). 100% State Funded.
122	L	PROS Startup – Cash Advance (OMH Only) 100% State Funded
122	P	Prior Year Liability (OMH Only) – Prior year liabilities reported in current year.

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DMH Code #	OMH Only Index	Description
122	U	PROS Start-Up Grants (OMH Only)
122	W	Western Care Coordination Project – Reallocated Savings (OMH Only) – Off the top funding for the Western Care Coordination Project.
130		Transitional Care - (OMH Only 100%)
152		Developmental Disabilities Program Council - (OPWDD Only 100%)
153		Article 16 Clinic Programs – (OPWDD Only)
154		Traumatic Brain Injury - (OPWDD Only 100%) - Agencies are provided State Aid up to 100% of the net operating costs related to the provision of services to individuals with Traumatic Brain Injury. These services include: information, referral, counseling, advocacy training, intake and linkage to other professionals through client specific discussion.
155		Voluntary Preservation Project - formerly know as Voluntary Operated Maintenance Contract (also known as VAMM) - (OPWDD) 100% State Aided
162		Geriatric Health Act
164		Suicide Prevention
170	B	Kendra’s Assisted Outpatient (AOT) – Transitional Management (TM) – (OMH Only -100%).
170	C	Kendra’s Medication Grant Program (MGP) Administration – (OMH Only -100%).
170	D	Kendra’s Medication Grant Program (MGP) – (OMH Only -100%).
170	P	Kendra’s Proxy – Advance Directives – (OMH Only -100%).
188		Health Care Enhancement – (OPWDD Only)
189		Epilepsy Services – (OPWDD Only) – State Aid up to 100% of the net operating costs related to the provision of services to developmentally disabled individuals with epilepsy. Services include but are not limited to information and referral, counseling, education and support groups.
200		Community Reinvestment Services Fund - (OMH Only)
200	C	Supported Housing Workforce RIV - (OMH Only) – 100%
300		Homeless Mentally Ill Fund - (OMH Only)
400		Commissioner’s Performance Fund - (OMH Only) – 100%.
503	A	COLA - 2002/2003 3 Percent PATH COLA (OMH Only) - 100%
505		COLA – 2006/2007 2.8 Percent (OPWDD Only) – 100%
530		NYC Housing Resource Consortium (OPWDD Only) -100%

New York State Consolidated Budget and Claiming Manual	Subject: Appendix O – Guidelines for Depreciation and Amortization	Section/Page: 39.1
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This Appendix is not applicable for Office of Alcoholism and Substance Abuse Services (OASAS).

Depreciation

The Consolidated Fiscal Report (CFR) does not include schedules detailing depreciation expense on assets such as buildings, equipment and vehicles. However, the service provider is required to maintain depreciation schedules that include the following minimum information:

- Description of Asset
- Date of Acquisition
- Cost at Acquisition
- State/Federal Funding for Items
- Salvage Value
- Depreciation Method
- Useful Life Used for Depreciation Purposes
- Annual Depreciation Amount
- Accumulated Depreciation

The following general rules shall apply for the calculation and reporting of depreciation expenses:

- Assets having a unit cost of \$5,000 or more *and* a useful life of 2 years or more must be depreciated. Conversely, items having a unit cost less than \$5,000 *or* a useful life of less than 2 years may be expensed.
- Group purchases of like items should be treated as a single purchase. Group purchases of unlike items must be treated as if each item was purchased individually. Telephone systems and computer systems should be treated as a group purchase.
- For CFR purposes, the depreciable base is calculated by taking the total cost of the asset and subtracting the salvage value and the amount funded by State or Federal monies. (NOTE: Funds received via rates, prices, fees or net deficit funding should not be included in the calculation of State and Federal monies.) If 100% of the cost of an asset is funded specifically by State or Federal monies, the asset cannot be depreciated

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on the CFR. This will be a reconciling item between the CFR and the service provider's financial statements.

- Depreciation on assets which are shared among programs/sites or among program/sites and administration should be allocated on a reasonable basis. Documentation for the allocation basis must be available upon request. Refer to Appendices I and J.
- The "straight line method" of depreciation must be used for all classes of assets funded by OASAS, OMH, or State Education Department (SED). Use of the one month, six month, or full year convention is acceptable.

The method of depreciation for buildings, fixed equipment and capital improvements funded by OPWDD must be straight line. The method of depreciation for moveable equipment, furniture and fixtures funded by OPWDD may be straight line, "double declining balance" or "sum of the years digits". (For Aid to Localities funding, the straight-line method of depreciation is the only acceptable depreciation method).

When assets are shared by programs funded by more than one New York State agency, the rules of majority funding shall dictate.

- *The useful life of depreciable assets shall be the higher of the reported useful life or the useful life from the 2004 edition of the Estimated Useful Lives of Depreciable Hospital Assets. This document is available from:*

The Publisher:

*Health Forum, Inc.
1 North Franklin
28th Floor
Chicago, IL 60606*

The American Hospital Association:

*The American Hospital Association
840 Lake Shore Drive
Chicago, IL 60611*

The Estimated Useful Life Guidelines found at the end of this appendix must be used in the calculation of depreciation expense unless the service provider can justify that an alternative useful life is more appropriate. (The useful life guidelines in this appendix were obtained from the Estimated Useful Lives of Depreciable Hospital Assets- Revised 1998 Edition which is published by the American Heart Association (AHA) Health Data and Coding Standards Group.) Documentation to support the use of alternative useful lives must be available upon request.

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Amortization

The CFR does not include schedules that calculate the amortization expense related to intangible assets, organizational expenses, leaseholds, leasehold improvements and mortgage expense. However, the service provider is required to maintain amortization schedules which include the following minimum information:

- Description of Item
- Beginning Date of Amortization
- Length of Amortization
- Costs to be Amortized
- Accumulated Amortization
- Current Year Amortization

The following general rules apply for the calculation and reporting of amortization expenses:

- Organizational expenses are amortized over a period of 60 months, starting with the month the first participant is admitted to the program/site. Amortization of items which are shared among program/sites or among program/sites and administration should be allocated on a reasonable basis. Documentation for the allocation basis must be available upon request.
- Leasehold improvements are amortized over the term of the lease which includes any period for which the lease may be renewed, extended, or continued following either an option exercised by the service provider, or in the absence of an option, reasonable interpretation of past acts of the lessor and lessee pertaining to renewal, etc., unless the service provider establishes (omitting past acts) that it will probably not renew, extend, or continue the lease.
- Leasehold improvements which are the responsibility of the service provider under the terms of a lease are amortized over the useful life of the improvements or the remaining term of the lease, whichever is shorter.
- Mortgage expenses relate to the mortgages owed by the service provider and are amortized over the life of the mortgage. These expenses are *not allowed for OPWDD Residential Habilitation*.

New York State Consolidated Budget and Claiming Manual	Subject: Appendix P – Program Development Grants (PDGs) for OMH and OPWDD	Section/Page: 40.1
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Program Development Grants (PDGs)

Purpose

The purpose of Program Development Grant (PDG) funding is to assist residential service providers in commencing a new community residence program funded by Office of Mental Health (OMH).

Approval And Distribution Process

PDG costs shall be reimbursed at 100% and may be advanced to the service provider according to their payment schedule. All PDG costs shall be documented by the provider as described in the submitted budget and shall be approved by the applicable field office. PDG's may run off-cycle.

Applicable Costs

Costs relating to starting a community residence program are appropriate PDG costs. Such costs include but are not limited to: initial recruitment, staffing, minor construction or remodeling costs, rent or other costs related to the use of space, purchases of automobiles or vans, furniture, some property costs, some architectural costs, office equipment and all client related furnishings.

Administrative costs of any kind are not allowable. Do not allocate any such costs to the PDG costs.

Only those costs which have been approved and budgeted as PDG costs may be included. This process should not be confused with the normal differences between cost reporting and claiming (i.e., items over \$1,000 in cost must be capitalized on the cost report, but can be expensed in the current year on the claim if approved in the budget).

Reporting On The Consolidated Fiscal Report (CFR)

PDG costs should be reported as a separate program column. No units of service are associated with PDG costs. For OMH PDGs, enter "A0" as the program code index (for example, 6070 would become 6070 A0 for a Treatment/Congregate program receiving PDG funds).

New York State Consolidated Budget and Claiming Manual	Subject: Appendix P – Program Development Grants (PDGs) for OMH and OPWDD	Section/Page: 40.2
	For the Periods: January 1, 2010 to December 31, 2010 July 1, 2010 to June 30, 2011	Issued: February 15, 2010

Start-Ups - OMH

Purpose

The purpose of OMH Start-ups is to assist ongoing OMH service providers in purchasing equipment as a one time, non-recurring expense which, if included in the cost of the program, would exaggerate unit costs.

Approval And Distribution Process

OMH Start-up costs shall be reimbursed at 100% and may be advanced to the service provider according to their payment schedule. All OMH Start-up costs shall be documented by the service provider as described in the submitted budget and shall be approved by the applicable field office. OMH Start-ups may run off-cycle.

Applicable Costs

One time purchases or non-recurring costs are appropriate for OMH Start-ups. Such costs may include but are not limited to: major repairs due to emergency situations, purchases of vehicles, office equipment, consultant costs, which would have the effect of artificially increasing unit costs in an any one program year.

Administrative costs of any kind are not allowable. Do not allocate any such costs to OMH Start-up costs.

Only those costs which have been approved and budgeted as OMH Start-up costs may be included. This process should not be confused with the normal differences between cost reporting and claiming (i.e., items over \$1,000 in cost must be capitalized on the cost report, but can be expensed in the current year on the claim if approved in the budget).

Reporting On The CFR

OMH Start-up costs should be reported by using "A0" as the program code index after the four digit program code (for example, 6050 would become 6050 A0 for a Supported Housing program receiving Start-up funds).

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	For the Periods: January 1, 2010 to December 31, 2010 July 1, 2010 to June 30, 2011	Issued: February 15, 2010

Start-Ups – Office for People With Developmental Disabilities (OPWDD)

Purpose

The purpose of OPWDD Start-up funding is to assist residential and Day service providers in commencing new residential and day programs funded by OPWDD.

Approval And Distribution Process

OPWDD Start-up costs shall be reimbursed at 100%, and 90% may be advanced to providers according to their payment schedule. All OPWDD Start-up costs shall be documented by the provider as described in the submitted budget and shall be approved by the applicable regional office. OPWDD Start-ups may run off-cycle.

Applicable Costs

Costs related to starting a residential or day program are appropriate OPWDD Start-up costs. Such costs include but are not limited to: initial recruitment, staffing, minor construction or remodeling costs, rent or other costs related to the use of space, purchases of furniture, some property costs, some architectural costs or office equipment.

Administrative costs of any kind are not allowable. Do not allocate any such costs to the OPWDD start-up costs.

Only those costs which have been approved and budgeted as OPWDD Start-up costs may be included.

Reporting On The CFR

OPWDD Start-up costs should be reported as a separate program column. No units of service are associated with OPWDD Start-up costs. OPWDD Start-up costs should be reported under the program type code 0190.

New York State Consolidated Budget and Claiming Manual	Subject: Appendix Q – Guidelines for OMH Residential Exempt Income	Section/Page: 41.1
	For the Periods: January 1, 2010 to December 31, 2010 July 1, 2010 to June 30, 2011	Issued: February 15, 2010

These guidelines are to be utilized by all Office of Mental Health (OMH) providers who operate Community Residences, Family Based Treatment Programs or other residential programs which have exempt income. Exempt income is income generated that exceeds the fixed amount defined in the fiscal model. (Refer to the residential exempt income policy and guidelines for specifics). The procedures for reporting these amounts on the Consolidated Fiscal Report are as follows:

Exempt Income (all sources except Medicaid):

For budget and claiming purposes, all income received (income from sources other than Medicaid) is to be reported as appropriate on the Consolidate Fiscal Report (CFR). As noted in the Community Residence (CR) Contract Policy and Guidelines, exempt income has been defined as being that amount by which actual income received exceeds the amount of the fiscal model income and is to be excluded from application against budgeted gross expenses in determining net deficit (and is retained by the service provider). For budget and claiming purposes, "exempt" income should be reported as "non-Generally Accepted Accounting Principles (GAAP) Adjustments to Revenue" on line 39 of Schedule Department of Mental Health (DMH)-2.2.

For budget and claiming purposes, exempt income which is spent in the current contract period will be reported on the appropriate revenue lines of Schedule DMH-2.1 and expenditures from exempt income will be reported in the appropriate expense category (lines 5 through 10 of Schedule DMH-2.1). If exempt income is partially spent in the current contract reporting period, that which is unspent must be reported on line 39 of Schedule DMH-2.2.

For CFR reporting on the core schedules (CFR-1 to CFR-6), exempt income should be considered a revenue, reported on the accrual basis of accounting and be reported on line 10 of Schedule CFR-2 and lines 69, 70, 71 or 74 of Schedule CFR-1.

Medicaid Exempt Income

For budget and claiming purposes, all Medicaid income is to be reported on the CFR, on line 17 of Schedule DMH-2.1. As noted in the CR Contract Policy and Guidelines, exempt income has been defined as being that amount by which actual income received exceeds the amount of the Fiscal Model with all Medicaid income in excess of the Fiscal Model expectation, to be excluded from application against budgeted Gross Budget Expenses in determining net deficit (and is retained by the service provider). To differentiate "exempt" income on the CFR, "exempt" income should be reported as "non-GAAP Adjustments to Revenue" on line 39 of Schedule DMH-2.2.

For budget and claiming purposes, exempt income which is spent in the current contract period will be reported on line 17 of Schedule DMH-2.1; and expenditures from exempt income will be reported in the appropriate expense category (lines 5 through 10 of Schedule DMH-2.1).

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For CFR reporting on the core CFR schedules (CFR-1 to CFR-6), Medicaid Exempt Income must be considered a revenue, and be reported on the accrual basis of accounting on line 72 of Schedule CFR-1 and on line 10 of Schedule CFR-2.

Note: For budget and claiming purposes, exempt income not spent which is reported on line 39 of Schedule DMH-2.2 must be detailed by revenue source (Supplemental Security Income (SSI), Medicaid or other).

New York State Consolidated Budget and Claiming Manual	Subject: Appendix R – Position Titles and Codes	Section/Page: 42.1
	For the Periods: January 1, 2010 to December 31, 2010 July 1, 2010 to June 30, 2011	Issued: February 15, 2010

Select the position title and code that reflects functions performed by the individual(s) and enter the appropriate title and code number on Schedule Consolidated Fiscal Report (CFR)-4 and, if applicable, Schedule CFR-4A.

Note: Certain position titles are unique to individual New York State agencies. Be certain that the title used is acceptable for the New York State agency that provides your funding. Office of Mental Health (OMH) service providers should note that certain position title codes are only acceptable for certain types of OMH programs.

- **Agency administration staff must be assigned position title codes from 600 through 699.**
- **Local Governmental Unit (LGU program code 0890) staff must be assigned position title codes from 700 through 799.**
- **Program administration staff must be assigned position title codes from 500 through 599.**
- **Program/site staff must be assigned position title codes from 100 through 499.**

Below is an alphabetic listing of position titles to assist you in choosing appropriate titles. Following the alphabetic list is a numeric list of position title codes and definitions.

Position Title	Position Title Code
Accountant	606
Accountant/Bookkeeper	703
Administrative Assistant	612
Assessment/Intake (SED Only)	251
Assistant Executive Director	602
Assistant Mental Hygiene Director	702
Assistant Principal (SED Only)	515
Assistant Program Director	502
Case Manager	301
Clinical Coordinator (Does not apply to OPWDD)	342
Community Relations	610
Comptroller/Controller	603
Computer/Data/Statistical Specialist	609
Coordinator/Education Department Head (SED Only)	516
Counseling Aide/Assistant-Alcoholism and Substance Abuse (Does not apply to SED)	268
Counselor - Alcoholism and Substance Abuse (SED use Code 305)	267
Counselor - Rehabilitation (Master's Level)	305

New York State Consolidated Budget and Claiming Manual	Subject: Appendix R – Position Titles and Codes	Section/Page: 42.2
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Position Title	Position Title Code
Counselor (OMH CR Only)	203
Crisis Intervention Worker (SED Only)	243
CSE/CPSE Chairperson (SED Only)	511
Curriculum Coordinator/IEP Coordinator (SED Only)	237
Developmental Disabilities Specialist/Habilitation Specialist- QMRP - Clinical (OPWDD & SED Only)	309
Developmental Disabilities Specialist - QMRP - Direct Care (OPWDD Only) (SED use 309)	207
Dietician/Nutritionist (OMH, OPWDD & OASAS Only)	336
Director of Division	604
Emergency Medical Technician	312
Executive Director/Chief Executive Officer	601
Family Counselor/Therapist	344
Food Service Worker (OASAS & OPWDD use 336 for Dietician/Nutritionist)	101
Guidance Counselor (SED Only)	236
Housekeeping and Maintenance	102
Identification/Information Referral (OASAS Only)	346
Intake/Screening	343
Intensive Case Manager (OMH Only)	313
Intensive Case Manager/Coordinator (OMH Only)	314
Job Coach/Employment Specialist (OMH, OPWDD Only)	254
Manager (OMH CR Only)	204
Marketing (Agency Administration)	614
Marketing (Program Administration)	509
Mental Hygiene Director/Commissioner of Mental Hygiene	701
Mental Hygiene Worker (not for OMH CR) (Does not apply to SED)	201
Nurse - Licensed Practical	316
Nurse Practitioner/Nursing Supervisor	315
Nurse – Registered	317
Nurses Aide/Medical Aide	339
Office Worker (Agency Administration)	605
Office Worker (LGU Administration)	704
Office Worker (Program Administration)	505
Other Agency Administration Staff	690
Other Clinical Staff/Assistants	390
Other Direct Care Staff	290
Other LGU Administration Staff	790
Other Program Administration Staff	590
Other Support Staff	190
Paraprofessional - Non-Disabled (SED Only)	265

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	For the Periods: January 1, 2010 to December 31, 2010 July 1, 2010 to June 30, 2011	Issued: February 15, 2010

Position Title	Position Title Code
Paraprofessional - Social Services (SED Only)	213
Pharmacist	350
Peer Specialist	266
Physician's Assistant	319
Physician - M.D.	320
Prevention/Education (OASAS Only)	345
Principal of School (SED Only)	514
Production Staff	400
Program Director	501
Program Research/Evaluation	510
Psychiatrist	318
Psychologist (Licensed)	321
Psychologist (Master's Level)/Behavioral Specialist	322
Psychology Worker/Other Behavioral Worker	323
Residence Worker (Does not apply to SED)	202
RTF (Residential Treatment Facility) Transition Coordinator (OMH Only)	352
Security	105
Senior Counselor (OMH CR Only)	205
Service Coordinator Medicaid Service Coordination (OPWDD Only)	351
Social Worker, Certified (CSW)	324
Social Worker Master's Level (MSW)	325
Staff Training (Agency Administration)	620
Staff Training (Program Administration)	520
Staff Training (Program/site) (OPWDD and SED only)	347
Supervising Teacher (SED Only)	215
Supervisor (OMH CR Only)	206
Supervisor - Social Services (SED Only)	513
Teacher Aide	228
Teacher Assistant	232
Teacher Aide/Assistant – Substitute	230
Teacher - Coverage/Floating (SED Only)	227
Teacher - Deaf (SED Only)	261
Teacher - Deaf/Blindness (SED Only)	263
Teacher - Hard of Hearing (SED Only)	262
Teacher - Non-Disabled (SED Only)	260
Teacher – Other	222
Teacher - Physical Education	220
Teacher - Special Education	218
Teacher – Speech Certified (SED Only)	225
Teacher - Substitute (SED Only)	224
Teacher - Vocational/Occupational Education (SED Only)	221

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	For the Periods: January 1, 2010 to December 31, 2010 July 1, 2010 to June 30, 2011	Issued: February 15, 2010

Position Title	Position Title Code
Therapist - Activity/Creative Arts	332
Therapist – Occupational	333
Therapist – Physical	334
Therapist – Recreation	330
Therapist – Speech	335
Therapy Assistant/Activity Assistant	337
Transportation Worker	104
Utilization Review/Quality Assurance (Agency Administration)	621
Utilization Review/Quality Assurance (Program Administration)	521
Utilization Review/Quality Assurance (Program/site) (OPWDD Only)	349

Note: Certain job titles are unique to individual New York State agencies. Be certain that the title used is acceptable for the New York State agency that provides your funding. OMH service providers should note that position titles are only acceptable for certain types of OMH programs.

Below is a numeric list of position title codes:

Code Number	Position Title/ Job Title(S)	Definitions
Support Staff		
101	Food Service Worker	All individuals associated with the supervision, preparation or production of food. Job titles may include: Baker, Butcher, Canteen Worker, Chef, Cook, Assistant Cook, Dietician, Dining Room Worker, Dishwasher, Food Manager, Assistant Food Manager, Kitchen Worker, Wait Staff. OASAS, OMH & OPWDD: Use Code 336 for Dietician/Nutritionist
102	Housekeeping and Maintenance	All individuals associated with the maintenance, cleaning and repair of the physical environment of a building. Job titles may include: Boiler Engineer, Carpenter, Chief Engineer, Cleaner, Custodian, Domestic Worker, Electrician, Engineer, Facility Related Workers, Foreman, Groundskeeper, Handyman, Housekeeper, Housekeeping Supervisor, Janitor, Maintenance Engineer, Maintenance Supervisor, Mason, Matron, Mechanic, Painter, Plumber, Porter, Supervisor of Physical Plant Operations.

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Code Number	Position Title/ Job Title(S)	Definitions
104	Transportation Worker	All individuals engaged in maintaining the vehicles for or providing or supervising the transportation of program participants. Job titles may include: Attendant, Bus Monitor, Driver, Escort, Transportation Aide, Transportation Coordinator, Transportation Supervisor, Transportation Worker.
105	Security	All individuals engaged in providing or supervising the security of a building. Job titles may include: Caretaker, Security Officer, Watchman.
190	Other Support Staff	All individuals engaged in providing or supervising other support services not listed in the 100 series. Job titles may include: Audio-Visual, Receiving Clerk, General Labor, etc.
Direct Care Staff		
201	Mental Hygiene Worker (not for OMH CR) (Does not apply to SED)	All individuals engaged in providing non-discipline specific services which involve the training of ADL skills; provide personal care to program participants; promote habilitation and/or rehabilitation. Job titles may include Habilitation Specialist, Residence Counselor, House Parents, ADL Specialist, Instructor and Trainer, Residence Staff, Relief Staff, House Apartment Worker.
202	Residence Worker (Does not apply to SED)	All individuals engaged in supervising non-discipline specific services which involve the training of ADL skills; provide personal care to program participants; promote habilitation and/or rehabilitation. Individuals in this position title do not perform any other administrative duties beyond the direct supervision of Direct Care staff. If other administrative functions are performed, allocate that portion associated with these functions using position code 501 or 502. Job titles may include Residence Director, Residence Manager, Hostel Manager, Residence Coordinator.
203	Counselor (OMH CR Only)	All individuals who perform this role as defined in the OMH Community Residence Program Model.
204	Manager (OMH CR Only)	All individuals who perform this role as defined in the OMH Community Residence Program Model.
205	Senior Counselor (OMH CR Only)	All individuals who perform this role as defined in the OMH Community Residence Program Mode.

New York State Consolidated Budget and Claiming Manual	Subject: Appendix R – Position Titles and Codes	Section/Page: 42.6
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Code Number	Position Title/ Job Title(S)	Definitions
206	Supervisor (OMH CR Only)	All individuals who perform this role as defined in the OMH Community Residence Program Model.
207	Developmental Disabilities Specialist QMRP – Direct Care (OPWDD Only) (SED Use Code 309)	All individuals not included within another listed title with at least a Bachelor's degree in an appropriate field or one year of experience working with the developmentally disabled engaged in providing or supervising services to program participants and their families. Job titles may include: Habilitation Specialist, Residence Counselor.
213	Paraprofessional - Social Services (SED Only)	All individuals under the immediate supervision and direction of a supervisor or caseworker and performs various support activities of case work services. Job title may include: Case Aide, Group Worker, Intern-Social Services, Family Advocate/Therapist.
215	Supervising Teacher (SED Only)	Provides for direct supervision of teachers. Job titles may include: Head Teacher, Assistant Teacher – Supervisor.
218	Teacher - Special Education	A certified teacher who provides specialized instruction to students with disabilities.
220	Teacher – Physical Education	Self-explanatory.
221	Teacher – Vocational/Occupational Education (SED Only)	Self-explanatory.
222	Teacher – Other	Self-explanatory. Job titles may include teachers of: Art, Music, Dance, Drama, Computer, Home Economics, Industrial Arts, Keyboarding; Learning Disability Specialist, Reading Specialist, Resource Room Teacher or teachers certified as Teacher of the Blind and Partially Sighted, Teacher of the Visually Impaired.
224	Teacher – Substitute (SED Only)	Self-explanatory. This is not a permanent position but is maintained on payroll records.
225	Teacher – Speech Certified (SED Only)	Certified as Teacher of Speech and Hearing Handicapped or Teacher of Deaf and Hearing Impaired.
227	Teacher - Coverage/Floating (SED Only)	An individual who covers sick days on a regular basis as a permanent position or as an extra teacher. The position is maintained on payroll records.

New York State Consolidated Budget and Claiming Manual	Subject: Appendix R – Position Titles and Codes	Section/Page: 42.7
	For the Periods: January 1, 2010 to December 31, 2010 July 1, 2010 to June 30, 2011	Issued: February 15, 2010

Code Number	Position Title/ Job Title(S)	Definitions
228	Teacher Aide	Assists teachers in non-teaching duties such as managing records, materials and equipment, attending to the physical needs of students and supervising students.
230	Teacher Aide/Assistant – Substitute	An individual who covers sick days of teacher aide or teacher assistant personnel. This is not a permanent position but it is maintained on payroll records.
232	Teacher Assistant	An individual who assists teachers in duties such as working with individual students or groups of students on special instructional projects, providing teachers with information about students, assisting students in the use of instructional resources, assisting teachers in the development of instructional materials and assisting in instructional programs.
236	Guidance Counselor (SED Only)	Self-explanatory. Job titles may include: School Counselor, Vocational Counselor.
237	Curriculum Coordinator/IEP Coordinator (SED Only)	Self-explanatory.
243	Crisis Intervention Worker (SED Only)	Self-explanatory. Also includes Child Guidance Worker.
254	Job Coach/Employment Specialist (OMH, OPWDD Only)	An individual who is responsible for the provision of intensive or extended training related services and supports necessary to obtain employment in the community or for the development of employment opportunities with business and industry.
260	Teacher – Non-Disabled (SED Only)	Self-explanatory. (For use in Preschool Integrated Programs).
261	Teacher – Deaf (SED Only)	Self-explanatory.
262	Teacher – Hard of Hearing (SED Only)	Self-explanatory.
263	Teacher - Deaf/Blindness (SED Only)	Self-explanatory.
265	Paraprofessional - Non- Disabled (SED Only)	Self-explanatory. (For use in Preschool Integrated Programs). Includes Non-Disabled Teacher Aides and Assistants.
266	Peer Specialist	Work with residents to facilitate the individual's recovery process.

New York State Consolidated Budget and Claiming Manual	Subject: Appendix R – Position Titles and Codes	Section/Page: 42.8
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Code Number	Position Title/ Job Title(S)	Definitions
267	Counselor – Alcoholism and Substance Abuse (CASAC) (SED Use Code 305)	An individual credentialed by the New York State Office of Alcoholism and Substance Abuse Services.
268	Counseling Aide/Assistant - Alcoholism and Substance Abuse (Does not apply to SED)	An individual functioning as defined for Alcoholism and Substance Abuse Counselor under supervision but who does not have a credential issued by the Office of Alcoholism and Substance Abuse Services.
290	Other Direct Care Staff	Anyone not listed in the 200 series engaged in providing direct care services.
Clinical Staff		
301	Case Manager	Supervises the implementation of each individualized program, monitors services received, records progress and initiates required periodic reviews. Job title may include: Client Coordinator.
305	Counselor - Rehabilitation	All individuals who have a degree in rehabilitative counseling from a program approved by the State Education Department or with current certification by the Commission on Rehabilitation Counselor Certification.
309	Developmental Disabilities Specialist/Habilitation Specialist QMRP – Clinical (OPWDD & SED Only)	All individuals not included in otherwise listed titles with at least a Bachelor's degree in an appropriate field from an accredited program and specialized training or one year experience working with the developmentally disabled engaged in providing or supervising services to program participants and their families.
312	Emergency Medical Technician	An individual certified by the New York State Department of Health for a period of three years as being qualified in all phases of medical emergency technology including, but not limited to communications, first aid, equipment maintenance, emergency room techniques and procedures, patient handling and positioning, and knowledge of procedures and equipment used for obstetrics, respiratory and cardiac emergencies who has passed an examination in the regular and advanced American Red Cross first aid courses and other training as required by the Commissioner of Health.

New York State Consolidated Budget and Claiming Manual	Subject: Appendix R – Position Titles and Codes	Section/Page: 42.9
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Code Number	Position Title/ Job Title(S)	Definitions
313	Intensive Case Manager (OMH Only)	An individual who will engage clients through outreach, monitor and coordinate evaluations and assessments to identify client needs, coordinate and participate with clients in the development of a service plan, provide coordination and assistance in crisis intervention and stabilization, assist in achieving service plan objectives, independence and productivity through "on the street" support, training and assistance in use of personal and community resources, assist in developing community supports and networks and advocate for changes in the system.
314	Intensive Case Manager/Coordinator (OMH Only)	In addition to the duties of the Intensive Case Manager, the Coordinator is responsible for supervising the Intensive Case Manager, monitoring the service dollars plan and expenditures, and negotiating with provider agencies for the care of clients.
315	Nurse Practitioner/Nursing Supervisor	Licensed professional nurse who has advanced certification through the American Nurses Association in a clinical specialty area or who has completed a program registered by SED and received a certification of completion in a clinical specialty area relevant to the treatment of the disability being treated.
316	Nurse – Licensed Practical	Licensed as a practical nurse by SED. Under the supervision of a supervisory nurse or registered nurse, the LPN administers prescribed medication and treatment to persons and assists in carrying out the planned health care program and maintenance of health records.
317	Nurse – Registered	Licensed as a registered nurse by SED. Under the supervision of a physician or a supervising nurse, this person provides direct treatment and dispenses prescribed medication.

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Code Number	Position Title/ Job Title(S)	Definitions
318	Psychiatrist	Licensed as a physician by SED and certified or eligible to be certified by the American Board of Psychiatry and Neurology. Responsible for providing psychiatric services, including diagnosis and prognosis for purposes of determining appropriate placement services. Also counsels other appropriate staff regarding individual therapy.
319	Physician's Assistant	Licensed and registered as such by SED and whose practice is in conformity with Section 3701 of the Public Health Law.
320	Physician - M.D.	Licensed by SED as a physician in general practice or specialized medicine.
321	Psychologist (Licensed)	Licensed as a psychologist by SED. Performs duties associated with the diagnosis and treatment of persons, including administering and interpreting projective and other psychological tests.
322	Psychologist (Master's Level)/ Behavioral Specialist	Individuals who have at least a Master's degree in psychology but are not licensed, and who provide routine psychological services under the supervision of a licensed psychologist.
323	Psychology Worker/Other Behavioral Worker	Individuals with less than a Master's degree in psychology, who provide routine psychological services under the supervision of a licensed psychologist.
324	Social Worker, Certified (CSW)	Individuals who are certified in this discipline by SED.
325	Social Worker - Master's Level (MSW)	Individuals with a Master's degree in social work who are not certified but who are engaged in the provision of routine social work.
330	Therapist – Recreation	Individuals who have a Bachelor's or Master's degree in therapeutic recreation from a program approved by SED or a registration in this discipline by the National Therapeutic Recreation Society.
332	Therapist - Activity/Creative Arts	Provide, supervise or direct professional activity or creative arts therapy services (music, art, etc.) and hold at least a Bachelor's degree and, where applicable, are certified by SED or a recognized national professional organization.
333	Therapist – Occupational	Individuals licensed in this discipline by SED.
334	Therapist – Physical	Individuals licensed in this discipline by SED.
335	Therapist – Speech	Individuals licensed in this discipline by SED.

New York State Consolidated Budget and Claiming Manual	Subject: Appendix R – Position Titles and Codes	Section/Page: 42.11
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Code Number	Position Title/ Job Title(S)	Definitions
336	Dietician/Nutritionist (OASAS, OMH & OPWDD Only)	An individual responsible for the planning of nutritionally balanced meals or overseeing special diets as prescribed by a physician.
337	Therapy Assistant/Activity Assistant	An individual performing functions defined as teachers or therapists not otherwise coded.
339	Nurse's Aide/Medical Aide	Under the supervision of the professional staff, assists in performing routine duties.
342	Clinical Coordinator (Does not apply to OPWDD)	Responsible for overseeing clinical aspects of the program, including staff supervision and case review.
343	Intake/Screening	An individual who is responsible for initial assessment, screening and referral of persons presented for admission
344	Family Counselor/Therapist	An individual responsible for providing assessment or counseling services to more than one member of the family in the same session.
345	Prevention/Education (OASAS Only)	An individual providing alcohol information education, training and program technical assistance to the community, schools, parents, young people, special target populations and other health and human service prevention and treatment providers.
346	Identification/Information Referral (OASAS Only)	An individual who identifies persons with problems that may be associated with alcohol use, provide screening and, when needed, information to accept a referral for assessment of appropriate treatment services.
347	Staff Training (OPWDD and SED Only)	An individual responsible for training of program participant care staff in the areas of counseling, record keeping, case management, etc.
349	Utilization Review/ Quality Assurance (OPWDD Only)	An individual responsible for monitoring adequacy and/or appropriateness of program participant services and for compliance with all applicable federal, state and local laws, regulations and policies.
350	Pharmacist	Licensed by SED and responsible for dispensing medications.

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Code Number	Position Title/ Job Title(S)	Definitions
351	Service Coordinator Medicaid Service Coordination (OPWDD Only)	An individual who provides MSC services in accordance with participant's Service Coordination Agreement and Individualized Service Plan (ISP). MSC service coordinators must meet the qualifications identified in the Medicaid Service Coordination Vendor Manual.
352	Residential Treatment Facility (RTF) Transition Coordinator (OMH Only)	An individual responsible for providing case management services for a child within the RTF; linking the child to local treatment and support at the time of discharge from the RTF; and providing time limited support to the child and family following discharge from the RTF to ensure a successful transition to a community setting.
390	Other Clinical Staff/Assistants	All individuals engaged in providing, supervising or specifically directing clinical services who are not included in the 300 series. Includes Dentistry, Radiology, Lab, Central Medical Supply.
Production Staff		
400	Production Staff	An individual engaged in providing, supervising or specifically directing production services including, but not limited to such titles as Production Manager, Workshop Supervisor, Warehouse Worker, Production Worker, Floor Supervisor, Contract Procurement Specialist, etc. Specify the title on Schedule CFR-4 and use this code number.
Program Administration Staff		
501	Program or Site Director	An individual responsible for the overall direct administration of: 1) a specific program type that operates at more than one site; or 2) multiple program types at a single site; or 3) a specific program type at a single site.
502	Assistant Program or Assistant Site Director	Assists either the Program Director or the Site Director in the direct administration of a specific program type. Job title may include: Assistant Education Director.
505	Office Worker	Responsible for record-keeping, billing, correspondence and general office duties.

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Code Number	Position Title/ Job Title(S)	Definitions
509	Marketing	An individual responsible for promoting the program's services for the primary purpose of increasing facility utilization.
510	Program Research/Evaluation	Responsible for conducting ongoing evaluation or research.
511	CSE/CPSE Chairperson (SED Only)	The individual that heads a multidisciplinary team that coordinates evaluations and recommends programs and services for school age or preschool students with disabilities.
513	Supervisor – Social Services (SED Only)	Staff who directly supervise or assist in the supervision of the provision of Clinical Services, Social Services, or Educational Related Services. May also include Supervising Teacher, Head Teacher.
514	Principal of School (SED Only)	Self-explanatory.
515	Assistant Principal (SED Only)	Self-explanatory.
516	Coordinator/Dept. Head (SED Only)	Self-explanatory. Job titles may include: Program Specialist, Director of Program Development, Program Coordinator/Manager.
520	Staff Training	An individual responsible for the training of program staff. (OPWDD and SED: Use Code 347).
521	Utilization Review/Quality Assurance	An individual responsible for monitoring the adequacy and/or appropriateness of program participant services and for compliance with all applicable federal, state and local laws, regulations and policies. (OPWDD: Use Code 349)
590	Other Program Administration Staff	Any program administration staff not listed in the 500 series. Job title may include: Supported Employment Coordinator.
Agency Administration Staff		
601	Executive Director/Chief Executive Officer	Responsible for the overall administration of the agency. This position is usually appointed by and is under the general direction of the governing board of the agency.

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Code Number	Position Title/ Job Title(S)	Definitions
602	Assistant Executive Director	Assists the Executive Director in the overall administration of the agency and acts on their behalf when necessary.
603	Comptroller/Controller	Responsible for overall fiscal management of the agency. Also includes Business Official, Director of Finance.
604	Director of Division	Responsible for overseeing a major segment of functions for the agency. Also includes Director of Admissions, Director of Purchasing, Director of Human Services, Director of Personnel, Director of Public Relations, Director of Data Processing
605	Office Worker	Responsible for agency-wide record-keeping, billing, correspondence and general office duties.
606	Accountant	Responsible for the establishment and maintenance of the agency's systematic fiscal transactions and preparation of financial statements for the agency. This position title does not include consultants.
609	Computer/Data/Statistical Specialist	Responsible for developing computer applications and/or provision of computer support.
610	Community Relations	Responsible for activities designed to present a positive public image of the agency/program.
612	Administrative Assistant	This position functions primarily as assistant to agency management in the performance of such activities as communications with internal or external parties, preparation of written work, liaison work, etc.
614	Marketing	An individual responsible for promoting the agency's services.
620	Staff Training	An individual responsible for training of agency staff.
621	Utilization Review/Quality Assurance	An individual responsible for monitoring the adequacy and/or appropriateness of the agency's services and for compliance with all applicable federal, state and local laws, regulations and policies
690	Other Agency Administration Staff	Includes all miscellaneous administration titles not included in the 600 series.
Local Governmental Unit Administration		
701	Mental Hygiene Director/ Commissioner of Mental Hygiene	The individual responsible for the overall direction of the mental hygiene activities/programs of the county

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Code Number	Position Title/ Job Title(S)	Definitions
702	Assistant Mental Hygiene Director	The individual who assists the Director/Commissioner of Mental Hygiene and acts in his/her behalf when absent in the overall direction of mental hygiene activity of the county.
703	Accountant/ Bookkeeper	The individual responsible for recording and maintaining mental hygiene fiscal transactions of the county.
704	Office Worker	The individual performing as secretary/clerk and/or billing mental hygiene programs of the county.
790	Other LGU Administration Staff	Any LGU administration staff that are not listed in the 700 series.

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Administering Agency	Code	CFDA
Federal:		
Employment and Training Administration	ETA	17.219, 17.232, 17.238, 17.243
Employment and Training Administration	ETAWIN	13.646
Health and Human Services Substance Abuse Prevention and Treatment (SAPT Block Grant)	HHS	93.959
Community Mental Health Services (CMHS) Block Grant		93.958
PATH Grant		93.150
Housing and Urban Development – Shelter Plus Care		14.238
Medicaid		93.775
Medicaid Salary Sharing		93.778
Office of Human Development Services	OHDSDD	13.630
Office of Human Development Services	OHDS	13.644
Department of Justice	DOJ	16.452, 16.541, 16.560, 16.561, 16.601, 16.602
National Institute on Mental Health	NIMH	13.242, 13.244, 13.281, 13.282, 13.295
National Institute on Alcohol Abuse and Alcoholism	NIAAA	13.252, 13.271, 13.272, 13.273, 13.274, 13.891, 13.898, 13.899
National Institute on Drug Abuse	NIDA	13.275, 13.277, 13.278
National Highway Traffic Safety Administration	NHTSA	20.600
Department of Education - Safe and Drug-Free Schools and Communities (SDFSC)	DOE	84.186
Office of Education	OE	13.427
Office of Education	OE1	13.446, 13.449
Office of Education	OE2	13.451, 13.489, 13.560
Office of Education	OE3	13.416, 13.482, 13.499
All Other Federal Education Programs	OE4	
U.S. Veteran's Administration	VA	
Old Age Survivors Disability Insurance	OASDI	
Federal Emergency Management Agency	FEMA	
All Other Federal Grants	OTHFED	
State:		
Medicaid Infrastructure Grant		93.768
Permanent Housing Program Project and Shelter Plus Care Project		14.238

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Some of the policies and procedures governing completion of Abbreviated Consolidated Fiscal Reports (CFRs) differ from those governing completion of Full CFRs. This section of the manual highlights the major differences and includes specific recommendations for completing Abbreviated CFR submissions.

Note: Sections 1 through 9 of this manual contain general information applicable to all types of CFR submissions. The New York State Agencies strongly recommend that staff responsible for completing the CFR read these first nine sections to ensure that they have a basic understanding of the CFR requirements.

Types of Abbreviated CFRs

There are three types of Abbreviated CFR submissions:

1. Abbreviated CFRs
2. Mini-Abbreviated CFRs
3. Article 28 Abbreviated CFRs

The three (3) types of Abbreviated CFRs have different combinations of required schedules and differing rules regarding the method of accounting that can be used on those schedules. There are also differing requirements for the submission of certified financial statements.

Please refer to Section 2 to verify that an Abbreviated CFR submission is appropriate for your agency.

Reporting Periods

The fiscal reporting period for all types of Abbreviated CFRs is generally determined by the physical location of the reporting organization's corporate headquarters. Please refer to Section 3 of this manual for more detailed information about CFR reporting periods.

Due Dates

All types of Abbreviated CFRs are due for submission no later than 120 days after the end of the fiscal reporting period. If a pre-approved extension request form has been submitted, the due date is no later than 150 days after the end of the fiscal reporting period. Please refer to Section 4 for more detailed information about CFR due dates.

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Software

Approved versions of NYS Consolidated Fiscal Reporting System (CFRS) software will create all types of Abbreviated CFRs. All of the State Agencies expect that filers of any type of Abbreviated CFR will use approved software to create that CFR and upload it via the Internet. Please refer to Section 5 for more detailed information about CFRS software.

Financial Statements

Submission of certified financial statements are required as part of some but not all types of Abbreviated CFRs. The following table indicates which types of Abbreviated CFRs require the submission of certified financial statements:

Abbreviated CFR Type	Financial Statements Required? Yes/No
Abbreviated CFR	Yes
Mini-Abbreviated CFR with OPWDD Programs	Yes
Mini-Abbreviated CFR without OPWDD Programs	No
Article 28 CFR	No

Please refer to Section 6 for more detailed information about certified financial statements.

Methods of Accounting

Some types of Abbreviated CFRs require that accrual accounting be used when preparing certain schedules while others allow all schedules to be completed using accrual, modified accrual or cash basis accounting. Claiming schedules of all types of Abbreviated CFRs may be completed using accrual, modified accrual or cash basis accounting as long as that method is consistent with the method used in developing the organization's approved budget. The allowable methods of accounting that can be used when completing Abbreviated CFR schedules are as follows:

Abbreviated CFR Schedules	Method of Accounting Allowed
Core: CFR-2, CFR-4, CFR-5, CFR-6 & DMH-1	Accrual Only
Claim: DMH-2 & DMH-3	Accrual, Modified Accrual or Cash

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Mini-Abbreviated CFR Schedules		Method of Accounting Allowed
Core: CFR-4 & CFR-5		Accrual, Modified Accrual or Cash
Claim: DMH-2 & DMH-3		Accrual, Modified Accrual or Cash

Article 28 Abbreviated CFR Schedules		Method of Accounting Allowed
Core: CFR-4 & DMH-1		Accrual Only
Claim: DMH-2 & DMH-3		Accrual, Modified Accrual or Cash

Note: The method of accounting used on the claim schedules of the Mini-Abbreviated CFR *must* be the same as the method of accounting used on the core schedules.

Please refer to Section 7 for more detailed information about methods of accounting.

Certification Schedules

The CFR-i and CFR-iii certification schedules are required for submission with all Abbreviated CFRs. Signed paper copies of these schedules must be mailed to each funding NYS agency and, if funded through a local county contract, the funding county.

Note: The Accountants Report (schedule CFR-ii/iiA) is not required for submission with Abbreviated, Mini-Abbreviated or Article 28 Abbreviated CFR. No type of Abbreviated CFR requires CPA certification.

Please refer to Sections 10 through 12 for more detailed information about certification schedules.

Recommended Order of Completion of CFR Schedules

The NYS Agencies recommend completing the schedules for all types of Abbreviated CFRs in a specific order. By completing the CFR using the recommended order of completion certain information can be brought forward from one schedule to another, unallowable/non-reimbursable related party costs can be determined and agency administration expenses can be allocated by the ratio value methodology.

Prior to completing the CFR schedules, it is imperative that the provider agency definition and program site(s) definitions have been created in the software.

The recommended order of completion for each type of Abbreviated CFR is as follows:

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Abbreviated Submissions:

- CFR-4, CFR-5, DMH-1 expenses except Agency Administration, CFR-2, DMH-1 Agency Administration Allocation and revenues, CFR-6, DMH-2, DMH-3.

Note: CFR-6 is not required to be completed by service providers who are funded/certified by OMH only.

Mini-Abbreviated Submissions:

- CFR-4, CFR-5, DMH-2, DMH-3.

Article 28 Abbreviated Submissions:

- CFR-4, DMH-1, DMH-2, DMH-3.

Schedule Completion Recommendations for Abbreviated CFRs

1. The program site CFR-4 is completed first so the total amount paid for personal services can be brought forward to the Personal Services line on schedule DMH-1 (line 6). Approved software will bring totals forward automatically. The agency administration CFR-4 should also completed at this time.

Please see Section 16 for detailed instructions on completing schedule CFR-4.

2. CFR-5 is completed to determine if any non-allowable expenses associated with related party transactions are included that must be reported on the Adjustments/Non-Allowable Costs line on DMH-1 (line 13) and DMH-2 (line 12). These adjustments must be data entered on both the DMH-1 and the DMH-2 schedules.

Note: Related party transactions may not be the only unallowable/non-reimbursable expenses that have to be entered on DMH-1, line 13 and DMH-2, 12. Please refer to Appendix X of this manual for a listing of some but not all unallowable/non-reimbursable items of expense.

Please see Section 18 for detailed instructions on completing schedule CFR-5.

3. DMH-1 expenses are brought forward to CFR-2. OASAS program expenses are brought forward to column 2, OMH program expenses are brought forward to column 3, OPWDD program expenses are brought forward to column 4 and Shared Program expenses are brought forward to column 6. Approved software will bring figures forward automatically.

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Please see Section 14 for detailed instructions on completing schedule CFR-2.

4. All of the expense lines for CFR-2, column 7, Other Programs except the Agency Administration Allocation are completed using the fiscal information contained in your agency's general ledger. The fiscal information in this column will reflect the expenses for all of your agency's non-CFR programs as well as the expenses associated with fund raising, special events, management contracts, unrealized gains/losses on investments, etc.
5. The net agency administration amounts entered on CFR-2, line 7, columns 2 through 7 **must** be calculated using the ratio value allocation method. Please see the section "Allocating Agency Administration by Ratio Value" at the end of this section for a detailed explanation of the ratio value allocation methodology.

Enter the allocated amount of agency administration and the revenue for each program reported on the appropriate lines of schedule DMH-1. For direct contract funded programs, all revenue received from OASAS, OMH or OPWDD is reported as Net Deficit Funding. For programs funded through a local contract with a county, all revenue received from OASAS, OMH, OPWDD and/or the county is reported as Net Deficit Funding. Approved software will total the line item amounts for each State Agency and automatically carry them forward to the appropriate line and column on schedule CFR-2.

6. All of the revenue lines for CFR-2, column 7, Other Programs are completed using the fiscal information contained in your agency's general ledger.
7. CFR-6 is completed reporting all Governing Board and Compensation information.

Please see Section 19 for detailed instructions on completing schedule CFR-6.

8. Transfer all items of expense and revenue from DMH-1 to DMH-2. Make all adjustments necessary to accommodate other than accrual accounting for claims. Be aware that OASAS and OMH allow for other than Ratio/Value Allocation Methodology for the allocation of Agency Administration on claims (DMH-2 and DMH-3). OPWDD only allows Ratio Value.

Please see Section 22 for detailed instructions on completing schedule DMH-2.

9. DMH-3 is completed indicating the appropriate funding source code(s) for each program reported.

Please see Section 24 for detailed instructions on completing schedule DMH-3.

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Schedule Completion Recommendations for Mini-Abbreviated CFRs

1. The program site CFR-4 is completed first so the total amount paid for personal services can be brought forward to the Personal Services line on schedule DMH-2 (line 5). Approved software will bring totals forward automatically. The agency administration, CFR-4, should also be completed at this time.

Please see Section 16 for detailed instructions on completing schedule CFR-4.

2. CFR-5 is completed to determine if any non-allowable expenses associated with related party transactions are included that must be reported on the Adjustments/Non-Allowable Costs line on schedule DMH-2 (line 12). These adjustments must be data entered on the DMH-2 schedule.

Note: Related party transactions may not be the only unallowable/non-reimbursable expenses that have to be entered on DMH-2, line 12. Please refer to Appendix X for a listing of some but not all unallowable/non-reimbursable items of expense.

Please see Section 18 for detailed instructions on completing schedule CFR-5.

3. DMH-2 expense lines (except Agency Administration Allocation) are completed using the fiscal information contained in your agency's general ledger.

Please see Section 22 for detailed instructions on completing schedule DMH-2.

4. Total net agency administration expenses **must** be allocated between State Agencies and all other non-CFR programs using the ratio value allocation method. Please see the section "Allocating Agency Administration by Ratio Value" at the end of this section for a detailed explanation of the ratio value allocation methodology.
5. Enter the allocated amount of agency administration and the revenue for each program reported on the appropriate lines of schedule DMH-2. For direct contract funded programs, all revenue received from OASAS, OMH or OPWDD is reported as Net Deficit Funding. For programs funded through a local contract with a county, all revenue received from OASAS, OMH, OPWDD and/or the county is reported as Net Deficit Funding.
6. DMH-3 is completed indicating the appropriate funding source code(s) for each program reported.

Please see Section 24 for detailed instructions on completing schedule DMH-3.

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Schedule Completion Recommendations for Article 28 Abbreviated CFRs

1. The program site CFR-4 is completed first so the total amount paid for personal services can be brought forward to the Personal Services line on schedule DMH-1 (line 6). Approved software will bring totals forward automatically. Agency Administration CFR-4 is not completed.

Please see Section 16 for detailed instructions on completing schedule CFR-4.

2. DMH-1 expense lines (except Agency Administration Allocation) are completed using the fiscal information contained in your agency's general ledger.

Please see Section 21 for detailed instructions on completing schedule DMH-1.

3. Enter the agency administration expenses for each program reported on the appropriate lines of each State Agency's DMH-1. Article 28 hospitals may use the same step-down methodology used in their Institutional Cost Report (ICR)
4. Enter the revenue for each program reported on the appropriate lines of schedule DMH-1. For direct contract funded programs, all revenue received from OASAS, OMH or OPWDD is reported as Net Deficit Funding. For programs funded through a local contract with a county, all revenue received from OASAS, OMH, OPWDD and/or the county is reported as Net Deficit Funding.

5. Transfer all items of expense and revenue from DMH-1 to DMH-2. Make all adjustments necessary to accommodate other than accrual accounting for claims.

Please see Section 22 for detailed instructions on completing schedule DMH-2.

6. DMH-3 is completed indicating the appropriate funding source code(s) for each program reported.

Please see Section 24 for detailed instructions on completing schedule DMH-3.

Allocating Agency Administration by Ratio Value

Agency administration expenses are allocated between the State Agencies and Other Programs using the ratio value allocation methodology. This method uses operating costs as the basis for the allocation. Operating costs in the Consolidated Fiscal Reporting System are defined as personal services, vacation leave accruals, fringe benefits and OTPS.

Note: The NYS CFRS software now includes an agency administration worksheet for Abbreviated and Mini-Abbreviated CFRs. This worksheet

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will calculate the six digit ratio value factor and distribute total agency-wide agency administration expenses between all applicable funding sources (OASAS, OMH, OPWDD and all other programs). The worksheet requires the user to enter an amount for total agency administrative costs (see step 3 below). It also includes a waiver option for situations where the provider is unable to use the ratio value.

The allocation of agency administration expenses between all funding sources is a multi-step process.

Step 1 For Abbreviated CFRs, subtotal the operating costs for each State Agency, the Shared Programs and the Other Programs by adding lines 1 through 4 in each column of schedule CFR-2. OASAS operating costs are totaled from column 2, OMH operating costs are totaled from column 3, OPWDD operating costs are totaled from column 4, Shared Program operating costs are totaled from column 6 and Other Program operating costs are totaled from column 7.

For Mini-Abbreviated CFRs, total OASAS operating costs, total OMH operating costs, total OPWDD operating costs and total non-CFR programs' operating costs are subtotaled from the information contained in your agency's general ledger.

Note: Operating Costs for programs 0190, 0880, and 0890 and Raw Materials reported for program 0340 are excluded from the calculations of Operating Costs (see Figure 1 for the calculation of Operating Costs).

Step 2 Calculate total agency operating costs by adding together the subtotals developed in Step 1.

Step 3 Calculate the total agency administration expenses for the entire organization from your agency's general ledger.

Step 4 Calculate the Ratio Value Factor by dividing the total agency administration expenses developed in Step 3 by the total agency operating costs developed in Step 2. Calculate the Ratio Value Factor to six (6) decimal places.

Step 5 Allocate total agency administration expenses to each State Agency and all other non-CFR programs by multiplying their respective operating costs by the Ratio Value Factor.

Step 6 For Abbreviated CFRs, allocate each State Agency's total share of agency administration between their respective programs on schedule DMH-1 using the Ratio Value Factor.
This step is not applicable for Mini-Abbreviated CFRs and OASAS-Only CFRs as these submission types do not include schedule DMH-1.

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Step 7 On the OASAS and OMH DMH-2 schedule, allocate the total agency administration expenses assigned to each State agency between their respective programs using the same method that was used to allocate agency administration costs on their approved operating budgets.

On the OPWDD DMH-2 schedule, allocate the total agency administration expenses assigned to OPWDD between the OPWDD programs using the Ratio Value Methodology.

The following charts represent the calculation and allocation of agency administration expenses by ratio value for an imaginary agency completing an Abbreviated CFR.

Steps 1 & 2
Calculation of Operating Costs for XYZ, Inc.
From Schedule CFR-2

Column		1	2	3	4	5	6	7
Line #	Expenses	Agency Totals	OASAS Totals	OMH Totals	OPWDD Totals	SED Totals	Shared Program Totals	Other Program Totals
1	Personal Services	144,000	29,000	75,000				40,000
2	Vac. Lv. Accruals							
3	Fringe Benefits	32,000	7,500	12,000				12,500
4	OTPS	24,000	3,500	13,000				7,500
MINUS Raw Materials								
Total Operating Expenses		200,000	40,000	100,000				60,000

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Steps 3 & 4

Calculation of Ratio/Value Factor for XYZ, Inc.

Total Agency Administration Expenses for XYZ, Inc.:		10,000
Calculation of the Ratio Value Factor	Total Administration Expenses	$\frac{10,000}{200,00} = .050000$ Ratio Value Factor
	Total Operating Costs	0

Step 5

Allocation of Agency Administration by Ratio/Value for XYZ, Inc.

For Schedules CFR-2 & DMH-1

Column	1	2	3	4	5	6	7
	Agency Totals	OASAS Totals	OMH Totals	OPWDD Totals	SED Totals	Shared Program Totals	Other Program Totals
Total Operating Costs (See Fig. 1 above)	200,000	40,000	100,000				60,000
Ratio Value Factor	.050000	.050000	.050000				.050000
Agency Administration Allocation	10,000	2,000	5,000				3,000

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From Step 1

Calculation of OMH Program-Specific Operating Costs for XYZ, Inc.

From Schedule DMH-1 OMH Programs

Column		1	2
Line #	Expenses	Program 0810	Program 1520
6	Personal Services	144,000	29,000
7	Vac. Lv. Accruals		
8	Fringe Benefits	32,000	7,300
9	OTPS	24,000	3,500
MINUS Raw Materials			
Total Operating Expenses		54,000	46,000

Step 6

Allocation of Agency Administration to OMH Programs by Ratio/Value

For Schedule DMH-1 OMH Programs

Column	1	2
	Program 0810	Program 1520
Total Operating Costs (See Fig. 3 above)	144,000	29,000
Multiplied by the Ratio Value Factor	.050000	.050000
Agency Administration Allocation	2,700	2,300

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Mental Hygiene Law 41-18 (Section b) Local Services Plan states "Local governments shall be granted State Aid in accordance with the provisions of this subdivision, for approved net operating costs pursuant to an approved local services plan at the rate of fifty percent of the amount incurred during the local fiscal year by such local governments and by voluntary agencies pursuant to contract with such local governments; provided, however, that a local government having a population of less than two hundred thousand shall be granted State Aid at the rate of seventy-five percent for the first one hundred thousand dollars of its approved net operating costs." The following is the distribution for these counties:

County Name	Population	OASAS	OMH	OPWDD	Total
Allegany	50,470	\$2,290	\$6,057	\$16,653	\$25,000
Cattaraugus	84,234	343	7,962	16,695	25,000
Cayuga	82,313	0	5,600	19,400	25,000
Chautauqua	141,895	0	25,000	0	25,000
Chemung	95,195	3,750	6,500	14,750	25,000
Chenango	51,768	3,000	12,000	10,000	25,000
Clinton	85,969	1,600	11,900	11,500	25,000
Columbia	62,982	0	12,500	12,500	25,000
Cortland	48,963	2,300	9,400	13,300	25,000
Delaware	47,225	1,900	4,400	18,700	25,000
Essex	37,152	10,000	10,000	5,000	25,000
Franklin	46,540	0	25,000	0	25,000
Fulton	54,191	4,000	18,000	3,000	25,000
Genesee	60,060	3,000	16,000	6,000	25,000
Greene	44,739	0	11,000	14,000	25,000
Hamilton	5,179	6,902	14,025	4,073	25,000
Herkimer	65,797	3,300	20,500	1,200	25,000
Jefferson	110,943	5,000	18,000	2,000	25,000
Lewis	26,796	0	12,500	12,500	25,000
Livingston	62,373	0	25,000	0	25,000
Madison	69,120	5,000	10,000	10,000	25,000
Montgomery	51,981	3,000	22,000	0	25,000
Ontario	95,101	1,300	11,600	12,100	25,000
Orleans	41,846	5,000	15,000	5,000	25,000
Oswego	121,771	5,000	15,000	5,000	25,000
Otsego	60,517	5,000	10,000	10,000	25,000
Putnam	83,941	3,896	14,400	6,704	25,000
Schenectady	149,285	12,500	12,500	0	25,000
Schoharie	31,859	4,729	3,973	16,298	25,000
Schuyler	18,662	2,000	11,500	11,500	25,000
Seneca	33,683	1,500	4,750	18,750	25,000
St. Lawrence	111,974	12,500	12,500	0	25,000
Steuben	99,088	6,645	6,968	11,387	25,000
Sullivan	69,277	1,900	4,900	18,200	25,000
Tioga	52,337	3,000	12,700	9,300	25,000

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County Name	Population	OASAS	OMH	OPWDD	Total
Tompkins	94,097	8,333	8,334	8,333	25,000
Ulster	165,304	2,300	14,800	7,900	25,000
Wayne	89,123	1,284	8,948	14,768	25,000
Wyoming	42,507	14,300	10,700	0	25,000
Yates	22,810	0	8,800	16,200	25,000
Total		\$149,072	\$510,717	\$365,211	\$1,025,000

OASAS Note: The portion of State aid allotted for those counties with a population under 200,000, is included in the State Aid for the 0890 LGU Administration program.

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These guidelines are to be utilized by all counties who receive Federal Medicaid Administrative Salary Sharing (Salary Sharing) revenue from Office of Mental Health (OMH). Through participation in the Salary Sharing program, counties can be reimbursed for part of the local governmental cost of (a) county staff time associated with the administration of the mental health portion of the Medicaid program and/or (b) subcontractors who administer the mental health portion of the Medicaid program. The local governmental costs associated with the administration of the mental health portion of the Medicaid program are hereafter referred to as *Local Medicaid Administration*.

Note: Counties are liable for all Salary Sharing claims subject to Federal and state audit, and are solely responsible for ensuring that their Salary Sharing claims for Local Medicaid Administration are in compliance with applicable Federal Regulations. Regarding Salary Sharing in general, please refer to Title 42 (Public Health) of the Code of Federal Regulations Consolidated Fiscal Report(CFR), Part 433 (State Fiscal Administration); regarding subcontracts specifically, please refer to Title 42, CFR Part 434.6 (General Requirements For All Contracts and Subcontracts). All documentation of contract specifications must be kept by the County.

Purposes Toward Which Local Medicaid Administration Salary Sharing Revenue Can Be Applied

Local Medicaid Administration Salary Sharing revenue is to be used for county/NYCDMH operated mental health services only, and must be applied toward either:

- mental health LGU Administration costs (OMH program 0890 – LGU Administration); or
- any other exclusively-OMH-funded, county/NYCDMH operated mental health program costs (i.e., programs that receive funding through OMH funding sources such as Local Assistance and Community Support Services (CSS), and this includes non-Medicaidable programs).

Procedure To Be Followed If Local Medicaid Administration Salary Sharing Revenue Is To Be Utilized For Lgu Program Expansion

If, during the course of the year, the Local Medicaid Administration Salary Sharing revenue received from OMH is used specifically for OMH LGU administration program expansion (OMH program 0890), then the expenditures related to LGU program expansion must be assigned entirely to OMH, and therefore, the total amount of LGU administration expenses split among the participating disabilities is to be reduced by an amount equal to the expenditures related to OMH LGU Administration program expansion. After the LGU Administration expenses have been reduced, calculate the shares assigned to each disability based on the "Department of Mental Health County Administration Percentage Splits for the Year 1988". The LGU

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Administration share assigned to OMH (based on the “splits”) is then to be increased by the expenditures made for OMH LGU administration program expansion.

Other Reporting Provisions

If a line utilized for the purpose of reporting Salary Sharing revenue contains revenues other than Salary Sharing revenue, then a subschedule that details all of the sources of revenue reported on this line needs to be attached to the CCR.

Procedures Specifically Regarding The Approved CFR Software

Providers who: (1) utilize approved CFR software for the purpose of completing year-end claiming schedules, and; (2) report all or some portion of the Salary Sharing revenue received from OMH in the LGU Administration program (under OMH program 0890) must ensure that the Salary Sharing revenue is *not* divided among the participating disabilities based on the "Department of Mental Health County Administration Percentage Splits for the Year 1988", but is applied entirely as an offset to the share assigned to OMH (you will need to directly enter this revenue information at the data entry screens for the schedules detailed above.)

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As a reminder, Chapter 166 of the Laws of 1991 added Article XI-B to the State Finance Law which promoted prompt contracting with not-for-profit (NFP) organizations and mandated by law prompt contract timeframes. If the NFP does not receive its first contract payment on time (i.e., in strict accordance with the contract payment schedule), the Department of Mental Hygiene will incur an interest penalty that will be payable from the State Operations appropriation. Since an annual report must be provided to the Governor's Office of Management and Productivity and the State Legislature regarding compliance with the timeframes for processing contracts and interest liabilities incurred, it is especially important that all NFP's receive their first contract payment on time.

A recent amendment to the Prompt Contract Law (PCL) adds some limited flexibility to the original provisions set forth in Article XI-B of the State Finance Law, and provides for a smoother flow of program services and payments. The revisions should enable State agencies to process contracts and payments for NFP's in a timely manner without incurring unreasonable interest liabilities. The revisions provide more reasonable timeframes for processing local grant awards (i.e., Legislative Member Items) and federally funded contracts; allow State agencies and NFP's to agree to waive interest payments in certain circumstances; eliminate interest penalties for contracts executed and funded in whole or in part for services rendered in a prior fiscal year; and limit the amount of time any one agency may suspend the law's timeframe to 4 ½ months in any State fiscal year.

The Division of the Budget has issued Budget Bulletin H-1016 which explains the revisions to the Prompt Contracting law. The key provisions of the budget bulletin are summarized below.

1. *Waiving Interest* - A State agency is permitted to process a contract with a NFP agency with a retroactive start date without being interest liable if the NFP agrees to waive interest.

Example: Funds for Member Items are appropriated April 1 but the recipient NFP agency is not identified until four months later. In the meantime, through their own choice, the NFP began providing services on April 1. The new provision of the law permits the State agency to process a contract with a retroactive start date of April 1 without incurring interest, but only after the NFP signs a waiver that removes the State agency from being interest eligible since it would otherwise appear that the State agency was four months later in processing the contract.

2. *Suspending Prompt Contracting* - Prompt contract timeframes may be suspended for up to 4 months if a State agency, OSC, the Division of the Budget, or the Attorney General determines that extenuating circumstances exist which prevent the State agency from complying with the PCL timeframes. State agencies are required to notify the NFP of the suspension in writing, and submit a copy of the notification to OSC, the chairman of the Assembly Ways and Means Committee, and chairman of the Senate Finance Committee. The notification must specify the length of the suspension.

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Example: A statewide Deficit Reduction Plan ("DRP") is issued, and because of the chaos usually associated with it, a "time out" from the prompt contract timeframes for processing contracts is called by the State agency. A written notice suspending the timeframes would be issued to the NFP. If such a notification is not issued, the State agency could be interest liable.

3. *Federally Funded Programs* - The new provision delays interest liabilities for federally funded contracts until four months after the State agency receives its federal funds, or after the contract's first payment due date, whichever is later.

Example: OMH could delay processing its CMHS Block Grant funded contracts until it has received its Notice of Block Grant Award from the federal government, and then take up to four months to process the contracts. However, OMH has been processing contracts to OSC and having them pre-approved ("executory"). This ensures that the contracts are processed within the prompt contract timeframes.

4. *Timeframes for Local Grant Award* - The timeframes for processing Member Item contracts begins on the date DOB informs the State agency with lists identifying the recipients of such contracts. The State agency then has four months from the DOB identification to process the contract to OSC, and as required by the current law, the AG and OSC have one month to complete the approval process, for a total timeframe of five months from identification. Without this new provisions, State agencies would have incurred interest liabilities because by the time the Member Items are identified, the timeframes for processing the contract have already expired.
5. *Contracts Supporting Prior Year Services* - Interest liabilities have been eliminated where State agencies execute contracts that are funded entirely or partially with current year appropriations to pay for services rendered in a previous fiscal year.

Finally, as a reminder, if the DMH agency determines that a significant and substantive difference exists between itself and the NFP in the negotiation of a contract or renewal contract, or if the DMH determines that the NFP is not negotiating in good faith, then the DMH may suspend the written directive and any subsequent interest payments or subsequent advance payments required to be provided. Upon such suspension, the DMH is required to provide the affected NFP with written notification of such determination and the reasons (see Prompt Contracting Law, Section 179-W[3]).

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This appendix lists certain items of expense that are considered non-allowable. Where this manual and/or state codes, rules and regulations are silent, DMH will defer to the guidelines published in the Federal Health Insurance Manual, commonly referred to as HIM-15. State Education Department (SED) providers should refer to the SED Reimbursable Cost Manual for specific items that are not allowable for SED programs. Office for People With Developmental Disabilities (OPWDD) providers should also refer to Appendix EE for Reimbursement Principles.

If any of the following expenses have been included on Schedules CFR-1 through CFR-5 and DMH-1 through DMH-3, they should also be included on the line for Adjustments/Non-allowable costs. Examples include but are not limited to the following:

1. Bad debts resulting from uncollectible accounts receivable and related costs.
2. Costs that are not properly related to program/site participant care or treatment and which principally afford diversion, entertainment, or amusement to owners, operators or employees.
3. Costs incurred by a service provider as a result of making a monetary contribution to another individual or organization (for example, political contributions, charitable contributions, etc.).
4. Costs related to interest expense for programs receiving Aid to Localities funding that are in excess of an approved rate, fee, contract or funded amount. This also includes expenses associated with the cost of borrowing (however represented) and costs of financing and refinancing operations and associated expenses except where specific authority exists and prior approval has been obtained from the appropriate DMH office. Interest paid to a related individual or organization is not allowable unless a provider is owned and operated by members of religious order and borrows from the Mother House or Governing Body of the religious order.
5. Costs resulting from violations of, or failure to comply with Federal, State and Local government laws, rules and regulations, including fines, parking tickets, or the costs of insurance policies obtained solely to insure against such penalty.
6. Dues or portions of dues paid to any professional association or parent agency whose primary function is of a political or lobbying nature and whose intent is to influence legislation or appropriation actions pending before Local, State or Federal bodies.
7. Cost increases created by the lease, sale or purchase of a program/site physical plant which has not received the prior approval of the appropriate Department of Mental Hygiene office.
8. Costs applicable to services, facilities and supplies furnished to the provider by organizations related to the provider by common ownership or control are excluded from allowable cost of the provider if it exceeds the cost to the related organization. Therefore,

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such cost must not exceed the lower of actual cost to the related organization or the price of comparable services, facilities or supplies that could be purchased elsewhere.

9. Costs of providing services and/or treatment to individuals who have not met the required eligibility criteria for the program/site.
10. Cost for contributions made to contingency reserve funds where such funds did not have prior approval by the appropriate DMH office. Contingencies do not include pension funds, self-insurance funds or funded depreciation accounts mandated by DMH offices.
11. Costs related to the purchase of alcoholic beverages.
12. Compensation to members of a Community Mental Health, Mental Retardation and Alcoholism Services Board, in excess of expenses incurred in the performance of official duties.
13. Costs for mental health clinics or other services operated exclusively in conjunction with schools. (Applicable to Aid to Localities funding only).
14. Costs associated with local governmental legislative bodies or executive staff not associated with the provision of DMH services.
15. Costs of books, subscriptions or periodicals which are not addressed to the provider agency.
16. Costs associated with the conferring of gifts or providing cash payment to an individual when the primary intent is to confer distinction on, or to symbolize respect, esteem or admiration for the recipient. If such gifts or honoraria constitute acknowledgement for services rendered, such as a speaker's fee, such costs are allowable.
17. Real estate taxes (except if part of a lease agreement or if part of purchase agreement), excise taxes on telephone services and other use taxes where organizations are eligible for exemptions from such taxes.
18. Costs incurred prior to the approved beginning date of a new program/site or expansion of a program/site unless such costs are specifically approved in writing by the required DMH office.
19. Costs incurred by a service provider that does not have an approved operating certificate or provider agreement where required, to render the particular services.
20. Costs associated with operating New York State Department of Motor Vehicle Drinking Driver programs including a prorated share of administration costs. (OASAS Only).

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21. Fees for psychiatric examinations under the Criminal Procedures Law or Family Court Act including fees paid to State employees if the examination is conducted during normal working hours (except for reasonable transportation expenses); fees paid to State employees if not accompanied by documentation from the County Fiscal Officer that there is a shortage of examiners in the county; fees above \$200 for one (1) person including both an examination and court appearance.
22. For programs funded through Aid to Localities, costs representing capital additions or improvements are unallowable as operating expenses (Title 14 NYCRR) unless specifically authorized in a legislative appropriation.
23. Unless specified judicially, the cost of services provided to an agency or a program participant of an agency in legal actions against the State.
24. For programs receiving funding through Aid to Localities, the costs associated with debt service, whether principal or interest are unallowable (Title 14 NYCRR). These operating costs may include that part of rental costs paid to those community health or mental retardation service companies that represent interest paid on obligations incurred by such companies organized pursuant to Article 75 and who participated in mortgage financing in accordance with Chapter 1304 of the Laws of 1969.
25. Costs associated with depreciation of assets purchased in whole or in part with State and/or Federal funds are unallowable. The provider's share of such depreciation is allowable based upon the proportional share of the asset purchased by provider funds. Do not make adjustments for assets purchased from fees, rates or net deficit funding. *NOTE: If asset purchases with a value of \$1,000 or more and a useful life of two years or more have been expensed for claiming purposes on Schedules DMH-2 and DMH-3, the corresponding depreciation should not be included as an expense on DMH-2 and DMH-3. Please refer to the equipment and property adjustment tables within DMH-2 instructions.*
26. Agency payment of individual employee professional licensing and/or credentialing fees.
27. Where appropriate, costs that need approval by the Division of Budget and approval has not been received.
28. Expenses that are not reasonable and/or necessary for providing services.
29. Fringe benefit expenses that are not reasonable and available to all employees.
30. Expenses that are prohibited by Federal, State or local laws.
31. Expenses included as a cost of any other program in a prior, current or subsequent fiscal period.

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32. Costs of investment counsel and staff and similar expenses incurred solely to enhance income from investments.

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Hospitals receiving funds from Department of Mental Health (DMH) via direct and/or indirect contracts are required to complete an abbreviated Consolidated Fiscal Report (CFR) which records with reasonable accuracy, discrete DMH costs.

The Institutional Cost Report (ICR) and the Medicaid Stepdown are not required to be submitted to DMH by the hospitals.

The following procedures are to be used exclusively by hospitals in filling out Schedule DMH-2.

The CFR is to be completed by hospitals using this manual as a guide.

In calculating expected administrative and overhead expenses, use the most recent available allocation percentages from the Medicaid stepdown derived from the last Institutional Cost Report (ICR) submitted to the Office of Health Systems Management. Follow this procedure unless there is reason to believe that there will be a change in the percentage that will be allocated to Mental Hygiene programs.

If ICR stepdown percentages are not used, please so indicate and explain the methodology used to calculate the percentages.

The logical integrity between the schedules in the CFR must be maintained as prescribed throughout the manual.

Hospitals who received State Aid based on a line item expense reimbursement methodology will continue to receive State Aid in this manner (based upon the procedures outlined above).

Hospitals who previously received State Aid based on approved Medicaid rates rather than on a line item expense reimbursement methodology will continue to receive State Aid based upon their approved Medicaid rates.

New York State Consolidated Budget and Claiming Manual	Subject: Appendix Z – In-Contract vs. Out-of-Contract (DMH Only)	Section/Page: 50.1
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When the Department of Mental Health (DMH) allocates deficit funding to a service provider, it is expected that these limited resources will be maximized on behalf of mental hygiene recipients. Specifically, this means that surpluses for approved mental hygiene programs should be utilized to offset deficits in other approved mental hygiene programs, thus allowing for optimal use of DMH State dollars.

With an effort to continue to maximize State Aid dollars and to establish a consistent in-contract/out-of-contract policy, the following policy for OMH funded agencies was implemented July 1, 1994 for the New York City region and January 1, 1995 for all upstate regions:

OMH Policy Statement: In-Contract/Out-of-Contract Reporting

The following medicaidable, ambulatory mental health programs must be reported as in-contract, even if net deficit funding is not supporting the program: Clinic Treatment; Continuing Day Treatment; Partial Hospitalization; Intensive Psychiatric Rehabilitation Treatment (IPRT); Intensive Case Management (ICM), Supportive Case Management (SCM); Assertive Community Treatment (ACT); and Day Treatment. Profits from any one of these programs must be used as an offset against net deficit funding in all other mental health programs except Community Residence, Family-Based Treatment, Personalized Recovery Oriented Services (PROS), Sheltered Workshop and Clinic Plus Programs. Inpatient programs will continue to be eligible for out-of-contract status at the discretion of the OMH Community Budget and Fiscal Liaison Units and therefore profits from these programs would not be used to reduce deficits in the above-listed programs.

Although Community Residence, Family-Based Treatment, PROS, Sheltered Workshop and Clinic Plus Programs are considered to be in-contract programs, by virtue of receiving State Aid net deficit funding, exempt income generated by one of these programs is not required to be used to offset in-contract deficits.

OMH Procedure: Reporting of In-Contract/Out-of-Contract

The Consolidated Budget Report (CBR) must continue the practice of containing all mental hygiene program activities by providers. Programs that are designated as in-contract must be listed by the appropriate funding source code on Schedule DMH-3 (Program Funding Summary) of the CBR, while those that are eligible to be designated as out-of-contract are to be reported under funding source code 090-Nonfunded. As a reminder, all programs that are designated as in-contract on the CBR must continue to be reported as in-contract on the Consolidated Claims Report (CCR).

Profits (except for exempt income defined above) generated by a provider from programs designated as in-contract are to be used to reduce the net deficit payable to that provider's other in-contract programs except the following OMH programs: Community Residence; and Family-Based Treatment and Sheltered Workshops. Application of these profits will be made during the desk audit of the CCR.

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Not included in this manual.

Please see the Consolidated Fiscal Reporting and Claiming Manual.

New York State Consolidated Budget and Claiming Manual	Subject: Appendix BB – Reserve for Future Use	Section/Page: 52.1
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Reserve For Future Use

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Local Governmental Units (LGUs) and municipalities that are required to submit a certified Consolidated Fiscal Report (CFR) may use the Compliance Review in lieu of the accountant's certification which appears on Schedule CFR-ii/CFR-iiA. The Compliance Review is intended to ensure that a CFR has been subjected to certain agreed upon procedures specified by the Department of Mental Hygiene (DMH). The Compliance Review must include the Document Control Number (DCN) of the CFR submission that was reviewed.

The certification must address the following for agreed upon procedures:

- Verification that there is a system in place and maintained for recording data in accordance with CFR definitions.
- Verification that source documents are available to support the reported data and are maintained for DMH review and audit for a minimum of 7 years following DMH's receipt of the CFR. The data must be fully documented and securely stored.
- Verification that there is a system of internal controls to assure the accuracy of the data collection process and recording system and that reported documents are not altered. Test that documents are reviewed and signed by a supervisor as required.
- Verification that the data collection methods are adequate to support the amounts reported.
- Verification that all amounts reported can be traced to supporting documentation.
- Documentation of an analytical review of the reported data to provide evidence that the CFR is reasonable and consistent with prior reporting periods, as well as other facts known about LGU/municipality operations.

DMH has specified and agreed to a set of procedures for the independent auditor to perform to satisfy the requirements of CFR Certification. Procedures a through i, as listed below, should be performed on Schedules: CFR-1, lines 13, 16,17, 20, 41, 48, 63, 64 through 67, 69 through 107; CFR-2; CFR-3; CFR-4; CFR-4A; CFR-5; DMH-1; OPWDD-3; OPWDD-4; and OMH-1.

- a. Obtain and review the Consolidated Fiscal Reporting Manual, as it relates to the schedules listed above.
- b. Discuss the procedures (written or informal) with the personnel assigned responsibility of supervising the preparation and maintenance of the CFR to ascertain:
 - The extent to which the LGU/municipality followed the established procedures on a continuous basis; and
 - Whether they believe such procedures are adequate to result in accurate reporting of data required by the CFR.

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- c. Inquire of same person concerning the retention policy that is followed by the LGU/municipality with respect to source documents supporting the CFR.
- d. Based on a description of the procedures obtained in items b and c above, identify all the source documents which are to be retained by the LGU/municipality for a minimum of seven years.
For each type of source document, observe that the document exists for the period.
- e. Discuss the system of internal controls with the person responsible for supervising and maintaining the CFR data. Inquire whether personnel independent of the preparer reviews the source documents and data summaries for completeness, accuracy and reasonableness and how often such reviews are performed. Perform tests, as appropriate, to ensure these reviews are performed.
- f. Test the mathematical accuracy of the report.
- g. Ensure summarization schedules agree to detail schedules, as prescribed by the CFR Manual.
- h. Obtain the supporting worksheets/reports utilized by the agency to prepare the final data which are transcribed to the CFR. Compare the data included on the worksheets to the amounts reported in the CFR. Test the arithmetical accuracy of the summarizations.
- i. Verify that the CFR software used to prepare the CFR is approved for the CFR reporting period.
- j. Verify that the books and records fully support the total of each amount entered on each line of the specified CFR schedules. Identify significant reconciling items and conclude on their propriety.

The auditor must document the specific procedures followed, personnel interviewed, documents reviewed, and tests performed in the work papers. The work papers should be available for DMH review for a minimum of seven years following the CFR report year.

The auditor may perform additional procedures which are agreed to by the auditor and the LGU/municipality, if desired. The auditor should clearly identify the additional procedures performed in a separate attachment to the certification report as procedures that were agreed to by the LGU/municipality and the auditor, but not by DMH.

CFR Agreed Upon Procedures Report Format:

The following is a suggested certification format for CFR data, and is strongly recommended:

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Community Mental Health Board
(name of LGU/municipality)

We understand that the (name of LGU/municipality) receives Medicaid reimbursement and/or Aid to Localities for programs funded by the New York State Department of Mental Hygiene (DMH) and in connection therewith, the LGU/municipality is required to report certain information to DMH.

DMH has established the following standards with regard to the data reported to it in the Consolidated Fiscal Report (CFR):

- A system is in place and maintained for recording data in accordance with CFR definitions.
- Source documents are available to support the reported data and maintained for DMH review and audit for a minimum of seven years following DMH's receipt of the CFR. The data are fully documented and securely stored.
- A system of internal controls is in place to assure the accuracy of the data collection process and that the recording system and reported documents are not altered. Documents are reviewed and signed by a supervisor, as required.
- The data collection methods are adequate to support the amounts reported.
- Reported amounts agree to supporting documentation.
- Reported amounts are consistent with prior reporting periods and other facts known about LGU/municipality operations.

We have applied procedures to the data contained in the accompanying CFR with Document Control Number _____, for the fiscal year-ending (date). Such procedures, which were agreed to and specified by DMH, were applied to assist you in evaluating whether the LGU/municipality complied with the standards described in the second paragraph of this report. Additional procedures performed, which are agreed to by the LGU/municipality but not by DMH, are described in a separate attachment to this report. This report is intended solely for your information and DMH, and should not be used by those who did not participate in determining the procedures.

The following information and findings came to our attention as a result of performing the procedures described in the attachments to this report.

Itemize all information and findings. If none, so state.

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The agreed upon procedures are substantially less in scope than an examination, the objective of which is an expression of an opinion on the CFR. Accordingly, we do not express such an opinion. Also we do not express an opinion on the LGU's/municipality's system of internal control taken as a whole.

In performing the procedures, except for the information and findings described above, no matters came to our attention which caused us to believe that the information included in the CFR for the fiscal year-ending (date) is not presented in conformity with the requirements established by DMH. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report relates only to the information described above, and does not extend to the LGU's/municipality's financial statement taken as a whole.

New York State Consolidated Budget and Claiming Manual	Subject: Appendix DD – OMH Level I COPS/CSP/Level II COPS Medicaid Revenue	Section/Page: 54.1
	For the Periods: January 1, 2010 to December 31, 2010 July 1, 2010 to June 30, 2011	Issued: February 15, 2010

The following guidelines are to be used for the purpose of budgeting and claiming Medicaid Revenue from: (a) Level I Comprehensive Outpatient Program (Level I COPS), (b) Community Support Program (CSP), and (c) Level II COPS fee supplement.

General Instructions

1. For Article 31 and Diagnostic and Treatment Center (D&TC) providers, Level I COPS, CSP, and Level II COPS revenue should be reported on the Consolidated Budget Report (CBR) and Consolidated Claiming Report (CCR) on the cash basis of accounting consistent with Section 3.0 of the Consolidated Budget Report (CBR) manual (the Methods of Accounting Section). This reporting requirement was implemented for the purpose of preventing discrepancies between the reserve amounts (overpayments) calculated by providers, and the revenue reconciliations calculated by the Office of Mental Health (OMH).
- (b) For Article 28 providers, Level I COPS and CSP revenue should be reported on the CBR and CCR on the accrual basis of accounting.
 - (c) For all providers, Level I COPS, CSP, and Level II COPS revenue should be reported on the core CFR schedules (CFR-1 through DMH-1) on the accrual basis of accounting in the column of the licensed outpatient program which generated the revenue up to the threshold limit. Level I COPS, CSP, and Level II COPS revenue received over the threshold limit must be reported on Line 39 - Other Non-Generally Accepted Accounting Principles (GAAP) Adjustments of the DMH-2.
 - (d) To assist providers in properly segregating and tracking their Level I COPS/CSP/Level II COPS Medicaid revenue, and identify any revenue that was received in excess of the threshold, OMH has designed a worksheet to help aid in this process. The worksheet is located at the end of this appendix.

Level I COPS

Level I COPS providers have the potential to generate Level I COPS revenue in excess of the Level I COPS threshold (the Level I COPS threshold represents the 110% Level I COPS amount (110% of corridor eligible funding and 100% of non-corridor eligible funding (500, Non-COPS, Shared Staff) that can be retained by the provider on an annual basis)). You may receive your threshold amount from the county, the field office, or the OMH COPS/CSP Rate Setting Unit. When Level I COPS overpayments occur, they will be recovered by the State through the Level I COPS reconciliation process by direct payment (a check) of the full amount to DOH or the 15% withhold method (a series of reductions that is no more than 15% of any Medicaid check). The recovery process is described in great detail in the letter DOH will send should a recovery take place. Therefore, it is in the best interest of all providers to monitor their Level I COPS revenue collections, and set aside those amounts that will be recovered (amounts set aside for recoveries are also referred to as Level I COPS reserves).

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Clinic services rendered on or after July 1, 2008 will no longer be subject to the Level I COPS Reconciliation process. All periods prior to July 1, 2008 are still subject to the Level I COPS Reconciliation process. For Upstate and Long Island providers the final Level I COPS clinic threshold is for the time period January 1, 2008 – June 30, 2008. For New York City providers the final Level I COPS Clinic Threshold is for the time period July 1, 2007 – June 30, 2008.

Budgeting on the CBR

- (a) Level I COPS revenue is to be budgeted on Line 17 - Medicaid of the DMH-2 in the column of the licensed outpatient program that is to generate the Level I COPS revenue. For Level I COPS clinic programs this amount is considered with the projected Level I COPS Clinic revenue for the outpatient program. For all other outpatient programs this amount is consistent with the Level I COPS Threshold.
- (b) Level I COPS revenue is to be allocated on the DMH-3 with all other Medicaid revenue consistent with the direction provided in Section 15.0 of the CBR manual (the DMH-3 Section).
- (c) Level I COPS overpayments from prior years do not need to be included on the budget (but need to be included on the claim).

Claiming on the CCR

- (a) Total Level I COPS revenue is to be claimed on Line 17 - Medicaid of the DMH-2. Use the Level I COPS line to record the Level I COPS revenue.
- (b) Level I COPS revenue that was reported on Line 39 - Other Non-GAAP Adjustments of the previous year's DMH-2 is to be reported on Line 29 - Other Revenue of the current year's DMH-2. Record the previous year's Level I COPS reserves (revenue in excess of the threshold (overpayments) generated during previous local fiscal years that have not yet been recovered by the State) on the Level I COPS Prior Years line.
- (c) Level I COPS reserves (revenue in excess of the threshold (overpayments) generated during the current local fiscal year **plus** any overpayments generated during previous local fiscal years that have not yet been recovered by the State) are to be reported on Line 39 - Other Non-GAAP Adjustments of the DMH-2. Use the Level I COPS reserve line to record the COPS reserve. Clinic services rendered on or after July 1, 2008 will no longer be subject to level I COPS Reconciliation process; therefore, a reserve is no longer applicable for the Level I COPS clinic program for services rendered on or after July 1, 2008. All periods prior to July 1, 2008 are still subject to the Level I COPS Reconciliation process and any Level I COPS Clinic reserves collected for those periods, if they have not yet been recovered by OMH, will need to be reported here.

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- (d) Level I COPS revenue is to be allocated on the DMH-3 with all other Medicaid revenue consistent with the direction provided in Section 24.0 of the CFR manual (the DMH-3 Section).
- (e) Providers are to continue to complete the CBR and CCR on a county-specific basis. Providers who operate Level I COPS programs that have locations in more than one county, or providers who operate Level I COPS programs at locations in one county, but provide Level I COPS services to residents of another county through a contractual arrangement, are to allocate Level I COPS overpayments to the participating counties consistent with the ratio of the Level I COPS threshold for the program type in that particular county to the agency's Total Level I COPS threshold for that particular county.

CSP

CSP providers have the potential to generate CSP revenue in excess of the CSP threshold (the CSP threshold represents the 100% CSP amount that can be retained by the provider on an annual basis). You may receive your threshold amount from the county, the field office, or the OMH Rate Setting Unit. When CSP overpayments occur, they will be recovered by the State through the CSP overpayment recovery process by direct payment (a check) of the full amount to DOH or the 15% withhold method (a series of reductions that is no more than 15% of any Medicaid check). The recovery process is described in great detail in the letter DOH will send should a recovery take place. Therefore, it is in the best interest of all providers to monitor their CSP revenue collections, and identify those amounts that will be recovered (amounts set aside for recoveries are also referred to as CSP reserves).

Budgeting on the CBR

- (a) Total CSP revenue is to be budgeted on Line 17 - Medicaid of the DMH-2 in the column of the CSP program for which the revenue is intended (and not in the column of the licensed outpatient program that is to generate the revenue).
- (b) CSP revenue is to be allocated on the DMH-3 with all other Medicaid revenue consistent with the direction provided in Section 15.0 of the CBR manual (the DMH-3 Section).
- (c) CSP overpayments from prior years do not need to be included on the budget (but need to be included on the claim).

Claiming on the CCR

- (a) CSP revenue is to be claimed on Line 17 - Medicaid of the DMH-2. Record the revenue on the CSP line.

Please note: It is the responsibility of (a) the LGU (in the case of CSP programs that are funded through the State aid approval letter), or (b) the direct contract provider (in the

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case of CSP programs funded through a direct contract between the State and the provider), that the CCR is submitted to ensure that the CSP revenue is reported in the column of the CSP program for which the revenue is intended. In the case of providers who receive CSP revenue for CSP programs funded through both the approval letter and a direct contract, it is the responsibility of the direct contract provider to inform the LGU of the proper amount of CSP revenue that is to be reported in the columns of the CSP programs funded through the approval letter).

- (b) CSP revenue that was reported on Line 39 - Other Non-GAAP Adjustments of the previous year's DMH-2 is to be reported on Line 29 - Other Revenue of the current year's DMH-2. Record the previous year's CSP reserves (revenue in excess of the threshold (overpayments) generated during previous local fiscal years that have not yet been recovered by the State) on the CSP Reserve Prior Years line.
- (c) CSP reserves (revenue in excess of the threshold (overpayments) generated during the current local fiscal year **plus** any overpayments generated during previous local fiscal years that have not yet been recovered by the State) are to be reported on Line 39 - Other Non-GAAP Adjustments of the DMH -2. Providers who receive CSP revenue in more than one type of outpatient program shall identify the CSP overpayments and shall report these overpayments in the program(s) where the overpayment has been received.
- (d) CSP revenue is to be allocated on the DMH-3 with all other Medicaid revenue consistent with the direction provided in Section 24.0 of the CFR manual (the DMH-3 Section).

Level II COPS

Level II COPS providers have the potential to generate Level II COPS revenue in excess of the Level II COPS threshold (the Level II COPS threshold represents the 100% Level II COPS amount that can be retained by the provider on an annual basis). You may receive your threshold amount from the county, the field office, or the OMH Rate Setting Unit. When Level II COPS overpayments occur, they will be recovered by the State through the Level II COPS overpayment recover process by direct payment (a check) of the full amount to DOH or the 15% withhold method (a series of reductions that is no more than 15% of any Medicaid check). The recovery process is described in great detail in the letter DOH will send should a recovery take place. Therefore, it is in the best interest of all providers to monitor their Level II COPS revenue collections, and set aside those amounts that will be recovered (amounts set aside for recoveries are also referred to as Level II COPS reserves).

Clinic services rendered on or after July 1, 2008 will not longer be subject to the Level II COPS Reconciliation process. All periods prior to July 1, 2008 are still subject to the Level II COPS Reconciliation process. For Upstate and Long Island providers the final Level II COPS Clinic Threshold is for the time period January 1, 2008 – June 30, 2008. For New York City providers the final Level I COPS clinic Threshold is for the time period July 1, 2007-June 30,2008.

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Budgeting on the CBR

- (a) Level II COPS revenue is to be budgeted on Line 17 - Medicaid of the DMH-2 in the column of the licensed outpatient program that is to generate the Level II COPS revenue. For Level II COPS Clinic programs this amount is consistent with the projected Level II COPS Clinic revenue for the outpatient program. For all other outpatient programs this amount is consistent with the level II COPS threshold.
- (b) Level II COPS revenue is to be allocated on the DMH-3 with all other Medicaid revenue consistent with the direction provided in Section 15.0 of the CBR manual (the DMH-3 Section).
- (c) Level II COPS overpayments from prior years do not need to be included on the budget (but need to be included on the claim).

Claiming on the CCR

- (a) Level II COPS revenue is to be claimed on Line 17 - Medicaid of the DMH-2. Record the revenue on the Level II COPS line.
- (b) Level II COPS revenue that was reported on Line 39 - Other Non-GAAP Adjustments of the previous year's DMH-2 is to be reported on Line 29 - Other Revenue of the current year's DMH-2. Record the previous year's Level II COPS Reserves from Line 39 - Other Non-GAAP Adjustments (revenue in excess of the threshold (overpayments) generated during previous local fiscal years that have not yet been recovered by the State) on the Level II COPS Prior Years line.
- (c) Level II COPS reserves (revenue in excess of the threshold (overpayments) generated during the current local fiscal year **plus** any overpayments generated during previous local fiscal years that have not yet been recovered by the State) are to be reported on Line 39 - Other Non-GAAP Adjustments of the DMH-2. Clinic services rendered on or after July 1, 2008 will no longer be subject to the Level II COPS Reconciliation process; therefore, a reserve is no longer applicable for services rendered by the Level II COPS Clinic program after July 1, 2008. All periods prior to July 1, 2008 are still subject to the Level II COPS Reconciliation process and any Level II COPS clinic reserves collected for those periods, if they have not yet been recovered by OMH, will need to be reported here.
- (d) Providers are to continue to complete the CBR and CCR on a county-specific basis. Providers who operate Level II COPS programs that have locations in more than one county, or providers who operate Level II COPS programs at locations in one county, but provide Level II COPS services to residents of another county through a contractual arrangement, are to allocate Level II COPS overpayments to the participating counties

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consistent with the direction provided in Section 15.0 of the CBR manual (the DMH-3 Section).

- (e) Level II COPS revenue is to be allocated on the DMH-3 with all other Medicaid revenue consistent with the direction provided in Section 15.0 of the CBR manual (the DMH-3 Section).

**Claiming and Reporting Worksheet
For Level I COPS, CSP, and Level II COPS**

**Enter Your
Amounts**

	Example:	Here:	Description
Level I COPS Threshold	\$100,000		Amount provided by the county, field office, or the OMH rate setting unit.
CSP Threshold	\$100,000		Amount provided by the county, field office, or the OMH rate setting unit.
Level II -COPS Threshold	\$0		Amount provided by the county, field office, or the OMH rate setting unit.

**Line 17 -
Medicaid:**

**Enter
Your
Amounts**

		Example:	Here:	Description
Level I COPS	a)	\$120,000		Current year Level I COPS revenue minus any Level I COPS recoveries made in the current year.
CSP	b)	\$40,000		Current year CSP revenue minus any CSP recoveries made in the current year.
Level II COPS	c)	\$0		Current year Level II COPS revenue minus any Level II COPS recoveries made in the current year.
Total: a + b + c		\$160,000		Equals the total Medicaid Revenue

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Line 29 - Other Revenue:		Enter Your Amounts		Description
	Example:	Here:		
CSP Reserve Prior Year	a) \$20,000			CSP Reserve from Line 39 - Other Non- GAAP Adjustments from prior year
Level I COPS Prior Year	b) \$20,000			Level I COPS Reserve from Line 39 - Other Non-GAAP Adjustments from prior year
Level II COPS Prior Years	c) \$0			Level II COPS Reserve from Line 39 - Other Non-GAAP Adjustments from prior year
Total: a + b + c	\$40,000			Equals total prior year reserves from previous years Line 39 - Other Non-GAAP Adjustments (overpayments)

Line 39 - Other Non-GAAP Adjustments:		Enter Your Amounts		Description
	Example:	Here:		
CSP Reserve	a) \$20,000			Current year CSP overpayment plus prior year CSP reserve not yet recovered
Level I COPS Reserve	b) \$40,000			Current year Level I COPS overpayment plus prior year Level I COPS reserve not yet recovered
Level II COPS Reserve	c) \$0			Current year Level II COPS overpayment plus prior year Level II COPS reserve not yet recovered
Total: a + b + c	\$60,000			Equals current year overpayments plus any prior year reserves not yet recovered

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The following is a set of guidelines which the Office for People With Developmental Disabilities (OPWDD) issued to all OPWDD funded service providers. The reimbursement principles became effective January 1, 1999 and set forth the decision principles by which OPWDD will determine allowed levels of reimbursement for the following categories of expense: meals, travel, professional fees and dues and subscriptions for personal purposes, entertainment, personal automobile use, agency provided vehicles, gifts, office furnishings, tuition, and housing. OPWDD will not reimburse provider expenses which exceed the guidelines contained in this document.

Costs Eligible for Reimbursement by OPWDD

The following principles shall be used by OPWDD to determine costs eligible for reimbursement:

- (1.) Any cost must be related to the provision of services to consumers, the enhancement of agency staff skill and training, the direct provision of services to consumers, or the operation of the agency.
- (2.) In order to be considered eligible for reimbursement, any cost is subject to the “prudent buyer” concept (i.e., the maximum spent should be what a typical buyer would reasonably expect to pay).

Meals

The cost of meals is eligible for reimbursement when staff and/or board members are in business related travel status, meeting with outside parties, or when engaged in board related business.

The cost of staff meals for those staff being honored at employee recognition events is eligible for reimbursement. In all cases, the expense of a meal includes the amount spent for food, non-alcoholic beverages, taxes and tip only.

Costs incurred by staff in the provision of direct service to consumers are considered program costs.

Travel Status

The cost of travel is eligible for reimbursement if the trip is related to the business of the agency. Expenses include the travel cost to and from the destination where the agency’s business will be transacted and any business related travel expenses (e.g., lodging, car rental, parking, tolls, taxi) while at the business destination. The least costly reasonable mode of transportation is eligible for reimbursement with reasonable consideration given to the requirements of the particular business circumstances at hand.

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Professional Fees and Dues and Subscriptions for Personal Purposes

Such costs are generally not eligible for reimbursement. However, costs for licensure or certification required as a condition of employment by the agency are eligible for reimbursement.

Entertainment

Costs which related solely to the amusement and diversion of staff, administration, or board members which are of no business benefit to the agency are not eligible for reimbursement. Costs incurred by the agency in the provision of annual holiday parties or picnics or employee recognition events are eligible reimbursement, subject to the prudent buyer concept.

Costs incurred by staff in the provision of direct consumer service are considered program costs.

Personal Automobile Related

Personal commuting costs, as defined by the Internal Revenue Service for tax purposes, are not eligible for reimbursement. Costs for business related use of a personal vehicle are eligible for reimbursement if the costs are ordinary and necessary. An ordinary cost is one that is common and accepted by the industry. A necessary cost is one that is required by the agency for the benefit of the agency or its consumers and not the individual staff or board member.

Agency Provided Vehicle

Costs associated with the acquisition or lease, operation, and maintenance of an agency owned vehicle used for agency related business, or costs associated with the personal use of an agency owned vehicle which are reported on the employee's IRS W-2 form as compensation, and determined by the board in written agency policy, are eligible for reimbursement. Costs in excess of the luxury vehicle threshold, as defined by the Internal Revenue Service, are not eligible for reimbursement.

Gifts

The cost of gifts is not eligible for reimbursement. Awards given for employee recognition purposes are not considered gifts.

Office Furnishings

The cost of office furnishings and decorations considered lavish or extravagant when compared to the prudent buyer concept, is not eligible for reimbursement. Fine art and collectibles are not reimbursable.

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Tuition

Cost for the training and educational enhancement of staff members are eligible for reimbursement where it can be demonstrated that such training and educational enhancement afforded the employee promotional opportunities within the agency and/or enhanced the quality of service delivery to consumers.

Housing

Costs associated with the provision of housing to agency personnel are eligible for reimbursement when the agency requires that such personnel reside on the grounds, or in close proximity to the facilities operated by the agency.