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.

Ambulatory Patient Group (APG): A defined group of outpatient procedures, encounters or ancillary services grouped for payment purposes. This Medicaid revenue is regulated in law 14NYCRR Part 599. Part 599 uses Ambulatory Patient Groups as the basis for Medicaid fee-for-service payments for mental health outpatient clinic services. The APG payment methodology is based on the Enhanced Ambulatory Patient Groups classification system, a product of the 3M Health Information Systems, Inc.

Amortization: The process of writing off a regular portion of the cost of an intangible asset over a fixed period of time. Refer to Appendix O - Guidelines for Depreciation and Amortization.

Arm's Length Transaction: A transaction entered into by unrelated parties, each acting in their own best interest. It is assumed that in this type of transaction, the prices used are the fair market values of the property or services being transferred in the transaction.

Asset: Property and service rights, measurable in terms of money, which the entity acquires for their economic benefit or value.

Building: The basic structure, shell and additions. The remainder is identified as fixed equipment. Land costs are not depreciable and should be excluded from building costs.

Capital Expenditure: The acquisition of both property and equipment having a useful life which extends over more than one accounting period. A capital expenditure either adds a fixed asset unit or increases the value of an existing fixed asset. Expenditures benefiting only the current year should be treated as an operating expense.

Closely allied entities (CAEs): Closely allied entities include corporations, partnerships, unincorporated associations or other bodies that have been formed or are organized to provide financial assistance and aid for the benefit of the service provider or receive financial assistance and aid from the service provider. Financial assistance and aid include engaging in fund raising activities, administering funds, holding title to real property, having an interest in personal property of any nature, and engaging in any other activities for the benefit of the service provider or the closely allied entity.

Community Support Programs (CSP revenue): Medicaid revenue that is added to the Medicaid rate of certain OMH outpatient programs in proportion to the amount of community support program state and local net deficit funding that has previously been replaced by CSP. This Medicaid revenue is regulated in law 14NYCRR Part 588.

Comprehensive Outpatient Programs (COPS revenue): Medicaid revenue that is added to the Medicaid rate of certain OMH outpatient programs in proportion to the amount of state and local net deficit funding that has previously been replaced by COPS. This Medicaid revenue is regulated in law 14NYCRR parts 592.

Controlling Party: Any person or organization who by reason of a direct or indirect ownership interest or designated responsibility (whether of record or beneficial) has the ability, acting either alone or in concert with others with ownership interest or designated responsibility, to direct or cause the direction of the management or policies of a corporation, partnership or other entity. Neither the commissioner nor any employee of DMH, SED nor any member of a local legislative body of a county or municipality, nor any county or municipal official except when acting as the administrator of a program shall, by reason of his or her official position, be deemed a controlling party of any corporation, partnership or other entity. For SED purposes, "Controlling Party" shall have the same meaning as "less-than-arm's-length relationship" as defined in Section 200.9 of the SED Commissioner's Regulations.

Department of Mental Hygiene (DMH): The agency in New York State charged with the responsibility for providing services for the care and treatment of mental illness, 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 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.

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.

MTA Tax (Metropolitan Commuter Mobility Tax): This is a tax imposed on certain employers (agencies) engaged in business within the metropolitan commuter transportation district (MCTD).

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 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.

Uncompensated Care: New York State has submitted a federal Medicaid waiver request to establish an indigent care funding pool for mental health clinics that is jointly funded by the State and federal government. Assuming the waiver is approved, the pool would offset a portion of losses from uncompensated care experienced by:

a. most Diagnostic and Treatment Centers licensed by DOH;
b. mental health clinics licensed by OMH that are not affiliated with hospitals or directly operated by OMH; and
c. clinics operated by some D&TCs not eligible to participate in DOH's Uncompensated Care distribution.

Unit of Service: The workload measure by which programs are evaluated. Units of service vary with the type of program provided.

The following lists commonly used acronyms:

Acronym	Translation
ACD	Agency for Child Development
ACT	Assertive Community Treatment
APG	Ambulatory Patient Group
CAE	Closely Allied Entity
CBR	Consolidated Budget Report
CCR	Consolidated Claiming Report
CDT	Continuing Day Treatment
CEO	Chief Executive Officer
CFDA	Catalog of Federal Domestic Assistance
CFR	Consolidated Fiscal Report
CFRS	Consolidated Fiscal Reporting System
CFO	Chief Fiscal Officer
CITER	OMH Center for Information Technology and Evaluation Research
CMHS	Federal Community Mental Health Services Block Grant
COPs	Comprehensive Outpatient Providers
CPA	Certified Public Accountant
CPEP	Comprehensive Psychiatric Emergency Program
CPSE	Committee for Preschool Special Education
CQR	Claiming Quarterly Report
CSE	Committee for Special Education
CSP	Community Support Program
CSS	Community Support Services
DA	Dormitory Authority
DCJS	Division of Criminal Justice Services
DCN	Document Control Number
DDSO	Developmental Disabilities Service Office
DHHS	Federal Department of Health and Human Services
DMH	Department of Mental Hygiene
DMV	Department of Motor Vehicles
DOH	Department of Health
DOL	Department of Labor
FBTP	Family-Based Treatment Program
FTE	Full Time Equivalent
GAAP	Generally Accepted Accounting Principles
HCBS	Home and Community Based Services
HUD	Federal Department of Housing and Urban Development
ICF	Intermediate Care Facility
ICM	Intensive Case Management

Acronym	Translation
IDEA	Federal Individuals with Disabilities Education Act Funds
IPRT	Intensive Psychiatric Rehabilitation Treatment
IRA	Individual Residential Alternative
ISP	Individual Service Plan
JAIBG	Federal Juvenile Accountability Incentive Block Grant
JCAHO	Joint Commission on the Accreditation of Health Care Organizations
LA	Local Assistance
LGU	Local Governmental Unit
LTSE	Long-Term Sheltered Employment
MATS	Managed Addiction Treatment Services
MCFFA	Medical Care Facilities Finance Agency
MHL	Mental Hygiene Law
MHPD	Mental Health Provider Data Exchange
MICA	Mentally Ill Chemical Abusers
MTA	Metropolitan Transportation Authority
NDF	Net Deficit Funding
NYCDOHMH	New York City Department of Health and Mental Hygiene
NYCRO	New York City Regional Office
OASAS	Office of Alcoholism and Substance Abuse Services
OCFS	Office of Children and Family Services
OMH	Office of Mental Health
OPWDD	Office For People With Developmental Disabilities
OSC	Office of the State Comptroller
OTPS	Other Than Personal Services
PDG	Program Development Grant
PHP	Permanent Housing Program
PRU	Program Reporting Unit
RCCA	Residential Care Center for Adults
RIV	Reinvestment
RRSY	Residential Rehabilitation Services for Youth
RTF	Residential Treatment Facility
RV	Ratio Value
SCM	Supportive Case Management
SED	State Education Department
SEIT	Special Education Itinerant Teacher
SPMI	Seriously and Persistently Mentally Ill
SRO	Single Room Occupancy
SSA	Social Security Administration
SSI	Supplemental Security Income

Acronym	Translation
TANF	Temporary Assistance for Needy Families
TPUR	Targeted Provider Utilization Review
TUBS	Temporary Use Beds
UPK	Universal Pre-K
UPL	Upper Payment Limit
VESID	Vocational and Educational Services for Individuals with Disabilities

New York State Counties

County	Code	County	Code
Albany	01	Niagara	32
Allegany	02	Oneida	33
Bronx	03	Onondaga	34
Broome	04	Ontario	35
Cattaraugus	05	Orange	36
Cayuga	06	Orleans	37
Chautauqua	07	Oswego	38
Chemung	08	Otsego	39
Chenango	09	Putnam	40
Clinton	10	Queens	41
Columbia	11	Rensselaer	42
Cortland	12	Richmond	43
Delaware	13	Rockland	44
Dutchess	14	St. Lawrence	45
Erie	15	Saratoga	46
Essex	16	Schenectady	47
Franklin	17	Schoharie	48
Fulton	18	Schuyler	49
Genesee	19	Seneca	50
Greene	20	Steuben	51
Hamilton	21	Suffolk	52
Herkimer	22	Sullivan	53
Jefferson	23	Tioga	54
Kings	24	Tompkins	55
Lewis	25	Ulster	56
Livingston	26	Warren	57
Madison	27	Washington	58
Monroe	28	Wayne	59
Montgomery	29	Westchester	60
Nassau	30	Wyoming	61
New York	31	Yates	62

Statewide – OMH Budgets and Claims Only

OMH Statewide Contracts – Calendar Year (OMH Only) – Use County Code 63

OMH Legislative Special Grants and OMH Statewide Contracts – July - June (OMH Only) - Use County Code 64

Non-New York State Counties

All Non-New York State Counties – Use County Code 80

Listed below are reasons why a Consolidated Fiscal Report (CFR) may be rejected. Reasons for rejection include but are not limited to the following:

1. Units of Service were not reported in accordance to the CFR Manual. It is critical that the units of service delivered during the reporting period are captured, counted and reported correctly.
2. All required programs were not reported.
3. A separate CFR was submitted for each State Agency instead of submitting a single consolidated CFR.
4. Schedule CFR-i was not signed and dated by the Executive Director.
5. Schedule CFRii/iiA, if required, was not signed and dated by an independent certified public accountant.
6. Schedule CFR-ii/iiA was altered to an unacceptable format.
7. The letter submitted by your independent accountant in lieu of CFR-ii/iiA differed significantly from the wording on Schedule CFR-ii/iiA.
8. A review was performed by your independent accountant when an audit was required.
9. The left-hand portion of Schedule CFR-iii (for service providers receiving Aid to Localities funding only) was not signed by the voluntary local service provider director or, if county-operated, the LGU's chief fiscal officer.
10. Areas of non-compliance addressed on desk reviews of prior period CFRs were not addressed by the service provider on their current CFR submission.
11. The program codes, program code indexes and/or site codes were incorrect.
12. When reporting periods coincide, total expenses and revenues reported on the service provider's certified financial statements differed materially from the total expenses and revenues reported on the CFR and the service provider did not submit a reconciliation of the differences.
13. All required schedules were not completed for all funding CFR State Agencies.
14. Required financial statements were not submitted.
15. The CFR submitted was not prepared using approved CFRs software.
16. The CFR was not transmitted electronically via the Internet.
17. The Document Control Number (DCN) of the Internet CFR submission did not match the DCN that appeared on the certification schedules CFR-i, CFR-ii/CFR-iiA and CFR-iii.
18. The wrong type of CFR submission was submitted (for example, an Abbreviated CFR was submitted instead of a Full CFR)
19. Expenses and revenue were not reported in accordance with the CFR Manual.

Below is a table of valid OASAS program types and their corresponding four (4) digit program codes grouped by service type. Following the table is a list of the valid program types in ascending program code order. Each program type in the list includes a program definition (where available), the OASAS operating regulation (where applicable) and the method used to measure and report units of service on the Consolidated Fiscal Report (CFR).

NOTE: The units of service reporting methods identified in this appendix apply to the reporting of units of service in the CFR *ONLY*. More complete information on OASAS service delivery reporting requirements can be found on the OASAS web site.

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
Compulsive Gambling Education, Assessment & Referral Services	Prevention	2790
Community Mobilization	Prevention	3001
Prevention Resource Centers	Prevention	3100
Chemical Dependence Prevention Services	Prevention	5550

Program Name	Service Type	Program Code
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 for 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 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.

Regulation: 823

Units of Service: Visits

0465 - Job Placement Initiative

Vocational rehabilitation focusing on job referrals and placement.

Regulation: Not Applicable

Units of Service: None for CFR

0507 - Underage Drinking Prevention

Activities designed to decrease underage drinking.

Regulation: Not Applicable

Units of Service: None for CFR

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.

Regulation: 828

Units of Service: Visits

0810 - Case Management

Activities aimed at linking the client to the service system and at coordinating the various services in order to achieve a successful outcome. The objective of case management in a mental health system is continuity of care and service. Services may include linking, monitoring and case-specific advocacy.

Linking: The process of referring or transferring a client to all required internal and external services that include the identification and acquisition of appropriate service resources.

Monitoring: Observation to assure the continuity of service in accordance with the client's treatment plan.

Case-Specific Advocacy: Interceding on the behalf of a client to assure access to services required in the individual service plan. Case management activities are expediting and coordinative in nature rather than the primary treatment services ordinarily provided by a therapist.

Case management services are provided to enrolled clients for whom staff are assigned a continuing case management responsibility. Thus, routine referral would not be included unless the staff member making the referral retains a continuing active responsibility for the client throughout the system of service.

Regulation: Not Applicable

Units of Service: None for CFR

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.

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.

Regulation: Not Applicable

Units of Service: None for CFR

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.

Regulation: Not Applicable

Units of Service: None for CFR

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.

Regulation: 828

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.

Regulation: 828

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

Regulation: 828

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

Regulation: 828

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, 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.

Regulation: Not Applicable At This Time

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.

Regulation: Not Applicable

Units of Service: None for CFR

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.

Regulation: Not Applicable

Units of Service: None for CFR

3039 - Medically Supervised Withdrawal Services – Inpatient/Residential

As defined in Part 816 of OASAS' regulations, medically supervised withdrawal services provided in an inpatient or residential setting must be provided under the supervision and direction of a licensed physician, and shall include medical supervision of persons undergoing moderate withdrawal or who are at risk of moderate withdrawal, as well as persons experiencing non-acute physical or psychiatric complications associated with their chemical dependence.

Such services are appropriate for persons who are intoxicated by alcohol and/or substances, who are suffering from mild withdrawal, coupled with situational crisis, or who are unable to abstain with an absence of past withdrawal complications.

Regulation: 816.7

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.

Regulation: 816.7

Units of Service: 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.

Regulation: Not Applicable

Units of Service: None for CFR

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.

Regulation: Not Applicable

Units of Service: None for CFR

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.

Regulation: Not Applicable

Units of Service: None for CFR

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.

Regulation: Not Applicable

Units of Service: None for CFR

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.

Regulation: Not Applicable

Units of Service: None for CFR

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.

Regulation: Not Applicable

Units of Service: None for CFR

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.

Regulation: 816.6

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.

Regulation: 816.8

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.

Regulation: 822

Units of Service: Visits

3528 - Enhanced Medically Supervised Outpatient

Regulation: Not Applicable

Units of Service: None for CFR

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.

Regulation: 822

Units of Service: Visits

3538 - Enhanced Outpatient Rehabilitation Services

Regulation: Not Applicable

Units of Service: None for CFR

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.

Regulation: 818

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' 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.

Regulation: 817

Units of Service: Patient Day

3560 - Intensive Residential

These programs assist individuals who suffer from chemical dependence, who are unable to maintain abstinence or participate in treatment without the structure of a 24-hour/day, 7 day/week residential setting and who are not in need of acute hospital or psychiatric care or chemical dependence inpatient services. In addition to counseling, peer group counseling, supportive services, educational services, structured activity and recreation and orientation to community services, intensive residential programs provide the following, either directly or by referral: vocational procedures such as vocational assessment, job skills training and employment readiness training; parenting, personal, social and community living skills training including personal hygiene and leisure activities. These services provide a minimum of 40 hours/week of procedures within a therapeutic milieu.

Regulation: 819

Units of Service: Patient Day

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.

Regulation: 819

Units of Service: Patient Day

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.

Regulation: 819

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).

Regulation: Not Applicable

Units of Service: None for CFR

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.

Regulation: Not Applicable

Units of Service: None for CFR

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.

Regulation: 820

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.

Regulation: 1045

Units of Service: None for CFR

4060 - Residential Chemically Dependency Program for Youth (Long-Term)

A voluntary residential recovery home program for youthful clients in a drug-free setting. It provides residential therapeutic care to those youths with a history of chronic chemical dependency. The program is part of a continuum of care for chemically dependent youths and may be operated by public, private not-for-profit or proprietary sponsors. The planned length of stay is more than 60 days but does not exceed 15 months.

Regulation: 823

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.

Regulation: Not Applicable

Units of Service: None for CFR

4074 - Support Services – Educational

Specialized chemical dependence related support services to provide educational services.

Regulation: Not Applicable

Units of Service: None for CFR

4075 - Community Services

Specialized chemical dependence related support services to provide community services by program staff, such as telephone crisis counseling.

Regulation: Not Applicable

Units of Service: None for CFR

4077 - Resource

Specialized chemical dependence related support services to provide resource support, such as training.

Regulation: Not Applicable

Units of Service: None for CFR

4078 - Program Administration

Specialized chemical dependence related support services to provide program administration.

Regulation: Not Applicable

Units of Service: None for CFR

4778 - Legislative Member Item

Programs that provide chemical dependence projects and services funded by General Fund, Local Assistance Account Member Item appropriations.

Regulation: Not Applicable

Units of Service: None for CFR

5550 - Chemical Dependence Prevention Services

Activities designed to decrease risk factors and increase protective factors for substance use and abuse.

Regulation: Not Applicable

Units of Service: None for CFR

5990 - Dual Diagnosis Coordinator

Specialized chemical dependence related support services to provide coordination of care for dually diagnosed patients.

Regulation: Not Applicable

Units of Service: None for CFR

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.

Regulation: 828

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.

Regulation: 828

Units of Service: Visits

General OMH Reporting Requirements

OMH service providers are required to report expenses and revenues for each program/site on the core and supplemental schedules of the CFR. In most cases, program/sites of the same program type are then aggregated on Schedules DMH-1, DMH-2 and DMH-3. The general program/site and program type reporting requirements are:

- Program/Site reporting on Schedules CFR-1, CFR-4, CFR-4A, OMH-1, OMH-2 and OMH-3.
- Program Type reporting on Schedules DMH-1, DMH-2, and DMH-3.

Exceptions to Program/Site Reporting (on CFR-1, CFR-4, CFR-4A, OMH-1, OMH-2 and OMH-3):

- *OMH Satellites*
  A satellite is defined as a physical extension of a program under that program's operating certificate. *Do not report these satellite programs on a site specific basis.* The expenses, revenues, and units of service will be included in the certified program.

- *OMH Start-up*
  OMH programs having a start-up component (as approved on their budget) will treat the start-up as a separate program and report revenue and expenses in the column adjacent to the program column that received the start-up funds. For OMH start-ups, enter "A0" as the program code index. Example: 6070 A0. If there are two or more start-ups for a particular program type, enter "A1" for the first occurrence, "A2" for the second occurrence, etc.

- *OMH Programs with multiple sites under the same license*
  Licensed programs are reported by program/site as designated under a specific operating certificate (i.e., for Treatment/Apartment programs (Program Code 7070), all apartments operating under a specific license must be reported together).

Exceptions to Program Type Reporting (on DMH-1, DMH-2 and DMH-3):

- The following programs *must* be reported by program/site throughout the CFR (including the claiming schedules): Permanent Housing Program (Program Code 1070), Family Based Treatment (Program Code 2040), Transient Housing (Program Code 2070), Treatment/Congregate (Program Code 6070), Support/Congregate (Program Code 6080), Comprehensive PROS with Clinic (Program Code 6340), Community Residence, Children & Youth (Program Code 7050), Comprehensive PROS without Clinic (Program Code 7340), Community Residence, Single Room Occupancy (Program Code 8050) and Supported SRO (Program Code 5070).

- The following OMH licensed programs must be reported by program/site on Schedules CFR-1, CFR-4 and CFR-4A and *can* be reported by program type on Schedules DMH-2 and DMH-3: Treatment/Apartment (Program Code 7070) and Support/Apartment (Program Code 7080).

CBR vs. CFR reporting

Programs should only be reported discretely if they are operated as individual programs and are not part of a larger program. Additionally, a program reported discretely on the approved CBR must also be reported discretely on all other fiscal documents submitted to OMH and the Health Department. For example, providers may not report a case management program's expenses and revenues as a discrete program on one document, but include those expenses and revenues as part of a clinic treatment program on a different document. Refer to the next item if a program/site is reported by funding source on the CBR.

When to report program/sites by funding source
OMH program/sites may be split by funding source (i.e., reinvestment versus non-reinvestment funding) *ONLY* on the claiming schedules (DMH-2 and DMH-3) *NOT* on the cost reporting schedules (CFR-1 through CFR-6). Please refer to the software instructions on the creation of additional sites on schedules DMH-2 and DMH-3 to accommodate these multiple occurrences.

When to Index Program Codes
OMH program codes may need to be indexed in certain situations when using software. If a service provider operates more than one program/site of the same program type (i.e., two treatment/ congregate facilities), which are not aggregated by program type on the claiming schedules, the program codes must be indexed.

The program codes are indexed on approved CFR software by the use of a two digit field following the four digit program code.

Example: A service provider operates three treatment/congregate facilities (6070). These program/sites are reported in three separate columns on the core schedules. This program type is not aggregated by program type on the claiming schedules, so these program/sites are also reported in three separate columns on Schedules DMH-1, DMH-2 and DMH-3. The program codes are indexed *throughout the CFR document* as 6070 01, 6070 02, and 6070 03.

Note: A person in crisis is an adult, child or adolescent who needs immediate intervention for the purpose of reducing acute and/or escalating psychiatric symptoms. The individual may be experiencing serious deterioration of social, personal and/or medical conditions that put him/her at risk for requiring hospitalizations and may be at risk of harming himself/herself or others.

Below is an alphabetical listing of OMH program types and the corresponding codes. Following this alphabetic list is a numeric list of program definitions and the corresponding codes.

ALPHABETICAL LISTING OF PROGRAM CODES

Program Type	Program Code
Adult Home Service Dollars	6920
Adult Home Supportive Case Management	6820
Advocacy/Support Services	1760
Affirmative Business/Industry	2340
Assertive Community Treatment (ACT) Program	0800
Assertive Community Treatment (ACT) Service Dollars	8810
Assisted Competitive Employment	1380
Blended Case Management	0820
Blended Case Management Service Dollars	0920
C&F Clinic Plus Outreach and Screening Services (Non-Licensed Program)	0790
Case Management Service Dollars Administration	2810
Clinic Treatment	2100
Community Residence, Children & Youth	7050
Community Residence for Eating Disorder Integrated Treatment Program (CREDIT)	6110
Community Residence, Single Room Occupancy (SRO)	8050
Comprehensive PROS With Clinic	6340
Comprehensive PROS Without Clinic	7340
Conference of Mental Hygiene Directors	2860
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/Respite Beds	1600
Crisis Residence	0910
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 (Non-Medicaid Programs)	1230
Geriatric Demo Gatekeeper (Non-Licensed Program)	1410
Geriatric Demo Physical Health-Mental Health Integration (Non-Licensed Program)	1420
HCBS Waiver Crisis Response	2260

Program Type	Program Code
HCBS Waiver Family Support	2250
HCBS Waiver Individualized Care Coordination	2230
HCBS Waiver Intensive-in-Home	2280
HCBS Waiver Respite Care	2240
HCBS Waiver Skill Building	2270
Home-Based Crisis Intervention	3040
Home-Based Family Treatment Model (Non-Licensed Program)	1980
Homeless Placement Services (Non-Licensed Program)	1960
ICM Service Dollars	1910
Inpatient Psychiatric Unit of a General Hospital	3010
Intensive Case Management	1810
Intensive Psychiatric Rehabilitation Treatment (IPRT)	2320
Limited License PROS	8340
Local Governmental Unit (LGU) Administration	0890
Local Governmental Unit (LGU) Administration - Reinvestment and Medication Grant Program (MGP) – OMH Only	0860
MICA Network	5990
Monitoring and Evaluation, CSS	0870
Multicultural Initiative	3990
Non-Medicaid Care Coordination	2720
Ongoing Integrated Supported Employment Services	4340
On-Site Rehabilitation	0320
Outreach	0690
Partial Hospitalization	2200
Permanent Housing Program (PHP)	1070
PROS Rehabilitation and Support Subcontract Services	9340
Psychosocial Club	0770
Recreation and/or Fitness	0610
Residential Treatment Facility – Children & Youth	1080
Residential Treatment Facility (RTF) Transition Coordinator	2880
Respite Services	0650
RTF/HCBS Service Dollars	2980
School Program Co-located with Clinic Treatment Program	1510
School Program without Clinic	1520
SCM Service Dollars	6910
Self-Help Programs	2770
Shelter Plus Care Housing (when funds flow through OMH, use 2070 when they do not)	3070
Sheltered Workshop/Satellite Sheltered Workshop	0340
Single Point of Access (SPOA)	1400
Special Legislative Grant	1190
Support Apartment	7080
Support Congregate	6080
Supported Education	5340
Supported Housing Community Services	6060
Supported Housing Rental Assistance	6050

Program Type	Program Code
Supported Single Room Occupancy (SP-SRO)	5070
Supportive Case Management (SCM)	6810
Teaching Family Home	4040
Transient Housing - THP, some PHP and some S+C (funds not flowing through OMH)	2070
Transition Management Services	1970
Transitional Employment Placement (TEP)	0380
Transportation	0670
Treatment Apartment	7070
Treatment Congregate	6070
Vocational Services – Children & Family (C & F)	1320
Work Program	3340

0040 - Family Care
(Licensed Program)

The Family Care program provides a 24-hour supervised setting, clinical services as needed and case management services to maximize linkages with community support services to persons who no longer require inpatient care, who cannot yet function in an independent living arrangement and who have demonstrated a functional level appropriate for living in a natural family environment.

Units of Service: Count one patient day as one unit.

0200 - Day Treatment
(Licensed Program)

Day treatment services for children and adolescents provide intensive, non-residential services. The programs are characterized by a blend of mental health and education services provided in a fully integrated program. Typically, these programs include education in small classes with an emphasis on individualized instruction, individual and group counseling, family services such as family counseling, crisis intervention, interpersonal skill development and behavior modification. Children and adolescents receiving day treatment services live at home or in the community but are identified by their school district as seriously emotionally disturbed and cannot be maintained in regular classrooms.

Units of Service:

- Brief Day Treatment: One to three hours.
- Half-day visit: Three but less than five hours.
- Full day visit: Five hours or over.
- Collateral visit: At least 30 minutes.
- Home visit: At least 30 minutes.
- Crisis-visit: At least 30 minutes.
- Pre-Admission full-day visit: At least five hours.
- Pre-Admission half day visit: At least three hours but less than five hours.

Total Units of Service: Add weighted visits by category to calculate a total.

0320 - On-Site Rehabilitation
(Non-Licensed Program)

The objective is to assist individuals disabled by mental illness who live in adult congregate care settings, supervised or supported living arrangements to achieve their treatment and community living rehabilitation goals. Services include one or a combination of: (1) consumer self-help and support interventions: (2) community living; (3) academic and/or social leisure time rehabilitation training and support services. These services are typically provided either at the residential location of the resident or in the natural or provider-operated community settings which are integral to the life of the residents. These on-site rehabilitation services are provided by a team that is either located at the residential site or which functions as a mobile rehabilitation team traveling from site to site.

Units of Service:

- Brief Day Visit: less than 3 hours.
- Half-day visit: 3 but less than 5 hours.
- Full-day visit: 5 hours or more.

Total Units of Service: Add weighted visits by category to calculate a total.

0340 - Sheltered Workshop/Satellite Sheltered Workshop
(Non-Licensed Program)

The objective is to provide vocational assessment, training, and paid work in a protective and non-integrated work environment for individuals disabled by mental illness. Services are provided according to wage and hour requirements specified in the Fair Labor Standards Act administered by the Department of Labor.

Units of Service:

- Brief day visit: Less than 3 hours
- Half-day visit: 3 but less than 5 hours
- Full-day visit: 5 hours or more

Total Units of Service: Add weighted visits by category to calculate a total.

0380 - Transitional Employment Placement (TEP)
(Non-Licensed Program)

The objective is to strengthen the individual's work record and work skills toward the goal of achieving assisted or unassisted competitive employment at or above the minimum wage paid by the competitive sector employer. TEP's provide time-limited employment and on-the-job training in one or more integrated employment settings as an integral part of the individual's vocational rehabilitation growth.

- Direct staff hours: The number of staff hours spent by staff in providing case management services face-to-face or by telephone directly to Consumers or collaterals.
- Indirect staff hours: The number of staff hours spent by staff in providing case management services on behalf of Consumers other than face-to-face or by telephone directly with Consumers or collaterals.

Units of Service: Count the total number of staff hours (combine direct and indirect).

0610 – Recreation and/or Fitness
(Non-Licensed Program)

A program of social, recreational, leisure and/or fitness activities that is intellectually, interpersonally and/or physically stimulating which can be but is not necessarily part of a goal-based program plan. Agencies which provide no other types of programs should report this service in this category. Recreation and/or fitness activities which are part of other programs should not be reported as part of this program.

Units of Service: Total the number of visits.

0650 – Respite Services
(Non-Licensed Program)

Temporary services (not beds) provided by trained staff in the consumer's place of residence or other temporary housing arrangement. Includes custodial care for a disabled person in order that primary care givers (family or legal guardian) may have relief from care responsibilities. The purpose of respite services is to provide relief to the primary care provider, allow situations to stabilize and prevent hospitalizations and/or longer term placements out of the home. Maximum Respite Care services per Consumer per year are 14 days.

Units of Service: Total the staff hours spent providing respite services.

0670 – Transportation
(Non-Licensed Program)

The provision of transportation to and from facilities or resources specified in the Consumer's individual treatment plan as a necessary part of his/her service for mental disability. This includes all necessary supportive services for full and effective integration of the Consumer into community life.

- A Consumer trip is the one-way transportation of a Consumer from one place to another. For example, transportation of one Consumer from home to the facility and back is counted as two trips; transportation of two Consumers to and from is counted as four trips.

Units of Service: Count the number of trips.

0690 – Outreach
(Non-Licensed Program)

Outreach programs/services are intended to engage and/or assess individuals potentially in need of mental health services. Outreach programs/services are not crisis services. Examples of applicable services are socialization, recreation, light meals, and provision of information about mental health and social services. Another type of service within this program code includes off-site, community based assessment and screening services. These services can be provided at forensic sites, a consumer's home, other residential settings, including homeless shelters, and the streets.

This program code should **not** be used for services that are provided by a licensed outpatient program. For unlicensed crisis type services use Program Code 2680 Crisis Intervention.

Units of Service: Total the number of contacts.

0770 - Psychosocial Club
(Non-Licensed Program)

The objective is to assist individuals disabled by mental illness to develop or reestablish a sense of self-esteem and group affiliation, and to promote their recovery from mental illness and their reintegration into a meaningful role in community life through the provision of two or more of the following: (1) consumer self-help and empowerment interventions; (2) community living: (3) academic; (4) vocational and/or (5) social-leisure time rehabilitation, training and support services.

Units of Service: Count each Consumer visit as one unit (no more than one unit of service per Consumer per day unless the Consumer returns for a planned evening program in which case count as two (2) units).

0790 – C&F Clinic Plus Outreach and Screening Services
(Non-Licensed Program)

C&F Clinic Plus Outreach and Screening Services are conducted by designated Child and Family Clinic Plus clinics. Mental Health screening under Clinic Plus is a broad based approach to identify children and adolescents with emotional disturbances, and intervene at the earliest possible opportunity. Screenings are provided in community settings, and with the prior written consent of the child's parent or legal guardian.

This code can only be used by providers who have been designated as a Child and Family Clinic Plus provider, and who operate a licensed Clinic Treatment program serving children.

Units of Service: Count each Contact as a unit of service.

0800 - Assertive Community Treatment (ACT) Program
(Licensed Program)

ACT Teams provide mobile intensive treatment and support to people with psychiatric disabilities. The focus is on the improvement of an individual's quality of life in the community and reducing the need for inpatient care, by providing intense community-based treatment services by an interdisciplinary team of mental health professionals. Building on the successful components of the Intensive Case Management (ICM) program, the ACT program has low staff-outpatient ratios; 24-hour-a-day, seven-day-per-week availability; enrollment of consumers, and flexible service dollars. Treatment is focused on individuals who have been unsuccessful in traditional forms of treatment.

Units of Service:

- Intensive Program Full Payment: Six or more face-to-face contacts per individual per month (may include 3 collateral visits) count as one unit.
- Intensive Program - Partial Payment: Between 2 and 5 face-to-face contacts per individual per month count as one unit.
- Supportive Program: 2 or more face-to-face contacts per individual per month count as one unit.

Total Units of Service: Total the number of contacts.

0820 – Blended Case Management
(Non-Licensed Program)

In addition to the general Targeted Case Management program description located in the Spending Plan Guidelines BCM facilitates a team approach to case management by combining the caseloads of multiple Intensive Case Managers (ICMs) and/or Supportive Case Managers (SCMs). 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.

Units of Service: Count the total number of contacts.

0860 - Local Governmental Unit (LGU) Administration - Reinvestment and Medication Grant Program (MGP)
(Non-Licensed Program)

This program category includes all local government costs related to administering mental hygiene services that are provided by a local government or by voluntary agency pursuant to a contract with a local governmental unit. This program can only be used with funding source codes 170C, 170D, 200, 300 and 400. Agency administrative costs allocated to the operating costs of this program via the Ratio Value allocation methodology are redistributed to other OMH programs in the CFR.

Units of Service: Not applicable.

0870 - Monitoring and Evaluation (CSS)
(Non-Licensed Program)

Funds provided for monitoring and evaluation activities associated with the program and fiscal management of the CSS program provided by a Core Service Agency and those costs incurred by the Local Government Unit for the Administration of the CSS program in those counties which have opted to administer the combined CSS/620 funding streams. Agency administrative costs allocated to the operating costs of this program via the Ratio Value allocation methodology are redistributed to other OMH programs in the CFR.

Units of Service: Not applicable.

0890 - Local Governmental Unit (LGU) Administration
(Non-Licensed Program)

The Local Governmental Unit is defined in Article 41 of the Mental Hygiene Law. This program category includes all local government costs related to administering mental hygiene services that are provided by a local government or by voluntary agency pursuant to a contract with a local governmental unit. This program does not include agency administration and can only be used with funding 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 Program)

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, 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. BCM Service Dollars may only be used on recipients receiving BCM, ICM, SCM or ACT Services and cannot be used for any other purpose. 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: 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.

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 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: 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 used for Medicaid Billing.

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
(Non-Licensed Program)

The objective is to assist individuals in choosing, finding, and maintaining satisfying jobs in the competitive employment market at minimum wage or higher. When appropriate, ACE provides these individuals with job related skills training as well as long-term supervision and support services, both at the work site and off-site.

- Direct staff hours: The number of staff hours spent by staff in providing case management services face-to-face or by telephone directly to Consumers or collaterals.
- Indirect staff hours: The number of staff hours spent by staff in providing case management services on behalf of Consumers other than face-to-face or by telephone directly with Consumers or collaterals.

Units of Service: Count the total number of staff hours (combine direct and indirect).

1400 Single Point Of Access (SPOA)
(Non-Licensed Program)

A SPOA is a process, *led by a SPOA Coordinator*, that helps Local Governmental Units achieve community-based mental health systems that are cohesive and well coordinated in order to serve those individuals most in need of services. There are three types of SPOAs - Children's, Adult Case Management and Adult Housing. The SPOA process provides for the identification of individuals most in need of services, and manages service access and utilization.

This program code should not be used for services that are provided by a licensed out-patient program.

Units of Service: Not applicable.

1410 – Geriatric Demo Gatekeeper
(Non-Licensed Program)

The Gatekeeper Program is designed to proactively identify at-risk older adults in the community who are not connected to the service delivery system. Gatekeepers are non-traditional referral sources who come into contact with older adults through their everyday work activities. They are specifically trained to look for signs and symptoms that may indicate the older adult is in need of assistance. The program increases public awareness of the needs of the older adults before a crisis occurs. Upon identification of an older adult in need, a trained Gatekeeper makes a phone call to trained staff which initiates the individual's assessment and a variety of in-home supportive services. The program is designed to keep at-risk seniors in their own homes, and prevent premature out-of-home placement. This program code should not be used for services provided by a licensed outpatient program, or for services provided by another active OMH funded program.

Units of Service: Count the total number of contacts.

1420 - Geriatric Demo Physical Health-Mental Health Integration (Non-Licensed Program)

The Physical Health-Mental Health Integration Program is designed to increase coordination and collaboration between and among physical health and mental health providers. The two integrated care models to be used in this demonstration are 1) the co-location of mental health specialists within primary care settings and 2) improved collaboration between separate providers. Older adults benefit from the increased convenience and coordination of mental and medical disorders. This program code should not be used for services provided by a licensed outpatient program, or for services provided by another active OMH funded program.

Units of Service: Visits

1510 - School Program Co-located with Clinic Treatment Program (Non-Licensed Program if reported under this code)

Services provided to children and adolescents with emotional/behavioral needs in a school setting in which a satellite clinic is located, as well as related supports provided to families and school staff. Services are in addition to those provided under the Clinic Treatment license, and can be provided to students not enrolled in the Clinic Treatment program. Program staff are generally also employees of the clinic and in school on a full-time basis or, at minimum, half-time basis. Family support staff may be employees of a local family support organization with which the program contracts. Services may be stand alone or, when the student is enrolled in the co-located clinic treatment program, coordinated with clinic treatment services. Program services include observation and assessment of children and adolescents for the purpose of determining need for mental health services; brief intervention (planned and unplanned); crisis intervention; group interventions; consultation with school staff and families; referrals to and coordination of services with other in-school or community-based providers; participation on school intervention team, Committee on Special Education, teacher or grade level teams, and other school committees dealing with the safety, health and well being of children and adolescents; collaboration with school health and social work staff; support groups for families and school faculty; classroom presentations; participation in parent/teacher conferences; participation in school events, such as parent orientations and health fairs; after school programming, and other related activities.

This program cannot be used to report expenses or revenues associated with services provided by the licensed Clinic Treatment Program (2100).

Units of Service: Total the number of staff hours.

1520 - School Program without Clinic (Non-Licensed Program)

Services provided to children and adolescents with emotional/behavioral needs in a school setting with no on-site mental health clinic, as well as related supports provided to families and school staff. Program staff are generally in school on a full-time basis or, at minimum, half-time basis. Family support services may be provided by a local family support organization with which the program contracts. Program services include observation and assessment of children and adolescents for the purpose of determining need for mental health services; brief intervention (planned and unplanned); crisis intervention; group interventions; consultation with school staff and families; referrals to and coordination of services with other in-school or community-based providers; participation on school intervention team, Committee on Special Education, teacher or grade level teams, and other school committees dealing with the safety, health and well being of children and adolescents; collaboration with school health and social work staff; support groups for families and school faculty; classroom presentations; participation in parent/teacher conferences; participation in school events, such as parent

orientations and health fairs; after school programming, and other related activities.

Units of Service: Total the number of staff hours.

1600 – Crisis/Respite Beds
(Non-Licensed Program)

A non-licensed residential program, or dedicated beds in a licensed program, which provide consumers a homelike environment with room, board and supervision in cases where individuals must be removed temporarily from their usual residence.

Units of Service: One resident day.

1650 - Family Support Services (Children and Family)
(Non-Licensed Program)

Family support programs provide an array of formal and informal services to support and empower families with children and adolescents having serious emotional disturbances. The goal of family support is to reduce family stress and enhance each family's ability to care for their child. To do this, family support programs operate on the principles of individualized care and recognizing every child and family is unique in their strengths and needs. Connecting family members to other families with children with serious emotional problems helps families to feel less isolated and identify their own strengths.

Family support programs ideally provide the following four core services: family/peer support, respite, advocacy, and skill building/educational opportunities.

Units of Service: Count the number of paid staff hours.

1680 – CPEP Crisis Outreach
(Non-Licensed Program - Associated with a Licensed CPEP Program)

A mobile crisis intervention component of the CPEP offering crisis outreach and interim crisis service visits to individuals outside an emergency room setting, in the community in natural (e.g. homes), structured (e.g., residential programs), or controlled (e.g., instructional) environments. Crisis outreach service visits are emergency mental health services provided outside an emergency room which include clinical assessment and crisis intervention treatment. Interim crisis service visits are mental health services provided to individuals who are released from a CPEP for the purpose of facilitating the individual's community tenure while waiting for the first post-CPEP visit with a community-based mental health provider.
CPEP crisis outreach and interim crisis service visits are Medicaid reimbursable.

This program is one of four program components which, when provided together, form the OMH licensed Comprehensive Psychiatric Emergency Program (CPEP). The other program components of the CPEP are: CPEP Crisis Intervention (3130), CPEP Extended Observation Beds (1920) and CPEP Crisis Beds (2600).

Units of Service:
- Crisis Outreach Visit
- Interim Crisis Visit.

Count the total number of visits.

1690 – FEMA Crisis Counseling Assistance and Training
(Non-Licensed Program)

A program to provide individual and/or group treatment procedures which are designed to alleviate the mental and emotional crises and their subsequent psychological and behavioral conditions resulting from major disaster or its aftermath. Funded through Federal Emergency Management Agency (FEMA). Agency administrative costs allocated to the operating costs of this program via the Ratio Value allocation methodology are redistributed to other OMH programs in the CFR.

Units of Service: Not applicable

1760 – Advocacy/Support Services
(Non-Licensed Program)

Advocacy/support services may be individual advocacy or systems advocacy (or a combination of both. Examples are warm lines, hot lines, teaching daily living skills, providing representative payee services, and training in any aspect of mental health services.

Individual advocacy assists consumers in protecting and promoting their rights, resolving complaints and grievances, and accessing services and supports of their choice.

Systems advocacy represent the concerns of a class of consumers by identifying patterns of problems and complaints and working with program or system administrators to resolve or eliminate these problems on a systemic, rather than individual basis.

Units of Service: Count the total number of contacts.

1770 - Drop-ln Center
(Non-Licensed Program)

The objective of a Drop In Center program is to identify and engage persons who may choose not to participate in more structured programs or who might not otherwise avail themselves of mental health services, and to provide services and supports in a manner which these individuals would accept. These programs are low demand, flexible and relatively unstructured, and responsive to individual need and circumstance.

Units of Service: Count the total number of units. Count each Consumer visit as one unit (no more than one unit of service per Consumer, per day, unless the Consumer returns for a planned evening program, in which case, count as two (2) units).

1810 - Intensive Case Management
(Non-Licensed Program)

In addition to the general Targeted Case Management program description located in the Spending Plan Guidelines, ICM is set at a case manager/client ratio of 1:12.

Medicaid billing requirements for the Traditional ICM model requires a minimum of four (4) 15 minute face-to-face contacts per 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 total number of contacts.

1910 - ICM Service Dollars
(Non-Licensed Program)

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. ICM Service Dollars may only be used on recipients receiving BCM, ICM, SCM or ACT Services and cannot be used for any other purpose. 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: 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.

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: Weighted Total

Cluster 1:

a. Completion of Psychosocial Summary
b. Completion of Psychiatric Evaluation
c. PPD Test Performed

For each item completed for each individual – Count as One Unit of Service

Cluster 2:

a. Completion of Public Assistance and/or SSI Application

b. Completion of (Medicaid) Application

For each item completed for each individual – Count as Two Units of Service

Cluster 3:

Enrollment in Mental Hygiene Services

For each enrollment for each individual – Count as Three Units of Service

Cluster 4:

Placement in Transitional Housing

For each individual placed in Transitional Housing – Count as Five Units of Service

Cluster 5:

Placement in Permanent Supportive Housing

For each individual placed in Permanent Supportive Housing – Count as Ten Units of Service

1970 – Transition Management (TM) Services
(Non-Licensed Program)

Transition Management Services (discharge planning) programs provide support for improved community service linkages and timely filing of Medicaid applications for seriously and persistently mentally ill (SPMI) consumers being released from local correctional facilities. The TM focus will be in obtaining post-release services for these consumers. TM can only be used with funding source code 170B.

Units of Service: The number of staff hours.

1980- Home-Based Family Treatment Model
(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 thru 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 visits.

2040 - Family Based Treatment Program
(Licensed Program)

The Family Based Treatment Program (FBTP) treats children and adolescents who are seriously emotionally disturbed within a home environment that is caring, nurturing and therapeutic. The program employs professional parents who are extensively trained and supervised. Parents function within a well-structured system that provides respite and other types of support; additionally, they are well paid in recognition of the high levels of responsibility and expectations placed on them by the model. Under the current FBTP initiative, a

single provider agency contracts with OMH to provide up to 40 homes. Each home is headed by professional parents. One family specialist is provided for each for each five professional parent couples and a respite couple to provide training, support, advocacy and supervision. The grouping of one respite couple and five professional families with one professional staff person forms the "cluster" which is the primary arena for providing professional parent supports, sharing child care data and experiences, and training.

Children served in the FBT Program are between the ages of five and 18, with the target population under 12 years of age. The children exhibit a variety of serious emotional problems.

Children are referred directly to the program by a variety of sources that include psychiatric inpatient programs, Residential Treatment Facilities (RTF's), community agencies and parents.

This is a type of Licensed Housing/Community Residential program for children and adolescents as defined in 14NYCRR594.

Units of Service: Count one resident day as one unit.

2070 - Transient Housing (THP, Some PHP and some S+C)
(Non-Licensed Program)

Housing and Urban Development (HUD) funds - Several federally funded programs contribute housing assistance specifically targeted to the homeless mentally ill. When funds do not flow through OMH, but are sent directly to the provider, the funds are reported under this program code and funding code 090 (non-funded) on the DMH-3. Federal Programs which fall into this category are Transitional Housing Program (THP), Supported Housing Demonstration Program (SHDP), and some Shelter Plus Care grants. Funds may be used for: the acquisition and/or rehabilitation of a program site; operating expenses; support services; and administrative expenses. These funds flow directly to the not-for-profit provider agencies from the federal Department of Housing and Urban Development. Nonetheless, OMH requires that any not-for-profit agency in receipt of these funds report the funds in a separate program column with the program code indexed if necessary. These grants are made for five years at a time.

Units of Service: Not applicable.

2100 - Clinic Treatment
(Licensed Program)

A clinic treatment program shall provide treatment designed to reduce symptoms, to improve patient functioning and to provide ongoing support.

A clinic treatment program for adults shall provide the following services: assessment and treatment planning, health screening and referral, discharge planning, verbal therapy, medication therapy, medication education, symptom management and psychiatric rehabilitation readiness determination. The following additional services may also be provided: case management, crisis intervention services, clinical support services and family treatment services.

A clinic treatment program for children shall provide the following services: assessment and treatment planning, verbal therapy, symptom management, health screening and referral, medication therapy, medication education, clinical support services and discharge planning. The following additional services may also be provided: case management, crisis intervention services and family treatment services.

- Brief visit: Shall be reimbursed for services of at least 15 minutes in duration but not more than 29 minutes of face-to-face interaction between one consumer and one therapist

- Regular visit: Shall be reimbursed for services of at least 30 minutes in duration of face-to-face interaction between one consumer and one therapist

- Crisis visit: Shall be reimbursed for services of at least 30 minutes in duration of face-to-face interaction between one consumer and one therapist

- Group therapy visits: Shall be reimbursed for services of at least 60 minutes duration provided to from 2 to 12 consumers and a therapist(s)

- Collateral visit: Shall be reimbursed for:

    - Clinical support services of at least 30 minutes in duration of face-to-face interaction between one or more collaterals and one therapist with or without a consumer; or

    - Family treatment services of at least 30 minutes in duration of face-to-face interaction among all of the following: a consumer, one or more family members, and a therapist.

Group collateral visit: shall be reimbursed for:

    - Clinical support services, as defined in Section 587.4(c) (5), of at least 60 minutes in duration but not more than 2 hours and shall represent services to more than one consumer and/or his or her collaterals. Such visits need not include consumers but shall not include more than 12 collaterals and/or consumers in a face-to-face interaction with a therapist for which reimbursement is claimed. Such limitation does not preclude the non-reimbursed participation of additional persons in the group session but such participation shall not be separately reimbursed; or

    - Family treatment services of at least 60 minutes in duration but not more than 2 hours and shall include services to more than one consumer. For each consumer participant, at least one family member shall participate. However, only one group collateral bill per consumer is allowed per day. Such visits shall not include more than 12 participants, including consumers and family members, for which reimbursement is claimed. Such limitation does not preclude the non-reimbursed participation of additional persons in the group session.

- Family visit: Shall be reimbursed for family treatment services, as defined in Section 587.4(c)(11), of at least 60 minutes in duration of face-to-face interaction between one consumer, one or more of his or her family members, and one therapist. For purposes of billing family visits which meet these criteria, providers shall bill one regular visit and one collateral visit.

Total Units of Service: Add weighted visits by category to calculate a total.

2200 - Partial Hospitalization
(Licensed Program)

A partial hospitalization program shall provide active treatment designed to stabilize and ameliorate acute symptoms, to serve as an alternative to inpatient hospitalization, or to reduce the length of a hospital stay within a

medically supervised program. A partial hospitalization program shall provide the following services: assessment and treatment planning, health screening and referral, symptom management, medication therapy, medication education, verbal therapy, case management, psychiatric rehabilitation readiness determination and referral, crisis intervention services, activity therapy, discharge planning and clinical support services.

Units of Service:

- Regular: shall be at least four hours and not more than seven hours;
- Collateral: shall be at least 30 minutes and not more than 120 minutes;
- Group Collateral: shall be at least one hour but may be up to two hours in duration.
- Crisis: shall be at least one hour but up to seven hours. In addition, pre-admission visits of at least one hour but up to three hours are allowable. These visits will be counted as crisis visits.

Total Units of Service: Add total service hours to calculate a total.

2230 – HCBS Waiver Individualized Care Coordination
(Non-Licensed Program)

Services that include the components of intake and screening, assessment of needs, service plan development, linking, advocacy, monitoring, discharge planning and consultation.

Units of Service: Total enrollee months, i.e. the 12 month total of each monthly census number (in months and half months) rounded to the next whole month.

2240 – HCBS Waiver Respite Care
(Non-Licensed Program)

A service that provides a needed break for the family and the child to ease the stress at home and improve family harmony. It may be provided on a planned or emergency basis either in home or out of home by trained respite workers.

Units of Service: Total either staff hours or per diem.

2250 – HCBS Waiver Family Support
(Non-Licensed Program)

Activities designed to enhance the ability of the child to function as part of a family unit and to increase the family's ability to care for the child in the home

Units of Service: Total staff hours.

2260 – HCBS Waiver Crisis Response
(Non-Licensed Program)

Activities aimed at stabilizing occurrence of child/family crises where they arise.

Units of Service: Total staff hours.

2270 – HCBS Waiver Skill Building
(Non-Licensed Program)

Activities designed to assist the child in acquiring, developing and accessing functional skills and supports - both social and environmental - needed to function more successfully in the community.

Units of Service: Total staff hours.

2280 – HCBS Waiver Intensive-in-Home
(Non-Licensed Program)

Ongoing activities aimed at providing intensive interventions in the home when a crisis response service is not enough.

Units of Service: Total staff hours.

2320 - Intensive Psychiatric Rehabilitation Treatment (IPRT)
(Licensed Program)

An intensive psychiatric rehabilitation treatment program is time-limited, with active psychiatric rehabilitation designed to assist a patient in forming and achieving mutually agreed upon goals in living, learning, working and social environments; to intervene with psychiatric rehabilitation technologies, to overcome functional disabilities and to improve environmental supports. An intensive psychiatric rehabilitation treatment program shall provide the following services: psychiatric rehabilitation readiness determination, psychiatric rehabilitation goal setting, psychiatric rehabilitation functional and resource assessment, psychiatric rehabilitation service planning, psychiatric rehabilitation skills and resource development and discharge planning.

Units of Service: Total service hours.

2340 - Affirmative Business/Industry
(Non-Licensed Program)

The objective is to provide vocational assessment, training, transitional or long-term paid employment, and support services for persons disabled by mental illness in a less restrictive/more integrated employment setting than sheltered workshops. Affirmative programs may include mobile contract services, small retail or wholesale outlets, and manufacturing and service oriented businesses.

Units of Service: Count the total number of Consumer hours.

2600 – CPEP Crisis Beds
(Non-Licensed Program)

A residential (24 hour/day) stabilization component of the CPEP, which provides supportive services for acute symptom reduction and the restoration of patients to pre-crisis level of functioning. These programs are time limited (up to five days) for patients until they achieve stabilization. Crisis beds serve persons experiencing rapid or sudden deterioration of social and personal conditions such that they are clinically at risk of hospitalization but may be treated in this alternative setting. CPEP crisis bed services are *neither* funded by OMH *nor* Medicaid-reimbursable, but are purchased from the facility operating these beds.

This program is one of four program components which, when provided together, form the OMH licensed Comprehensive Psychiatric Emergency Program (CPEP). The other program components of the CPEP are: CPEP Crisis Intervention (3130), CPEP Crisis Outreach (1680) and CPEP Extended Observation Beds (1920).

Units of Service: One resident day.

2680 Crisis Intervention
(Non-Licensed Program)

Crisis intervention services, applicable to adults, children and adolescents, are intended to reduce acute symptoms and restore individuals to pre-crisis levels of functioning. Examples of where these services may be provided include emergency rooms and residential settings. Provision of services may also be provided by a mobile treatment team, generally at a consumer's residence or other natural setting (not at an in-patient or out-patient treatment setting). Examples of services are screening, assessment, stabilization, triage, and/or referral to an appropriate program or programs. This program type does not include warm lines or hot lines. Use Advocacy/Support 1760 for such services.
This program code should **not be used for services that are provided** by a licensed out-patient program.

Units of Service: Count the total staff hours.

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 continuity of care and service. Services may include linking, monitoring and case-specific advocacy. Care Coordination Services are provided to enrolled consumers for whom staff is 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 with Medicaid may receive services from this program, however, the program does not receive reimbursement from Medicaid.

Units of Service: Count the total number of staff hours (combine direct and indirect).

2770 - Self Help Program
(Non-Licensed Program)

To provide rehabilitative and support activities based on the principle that people who share a common condition or experience can be of substantial assistance to each other. These programs may take the form of mutual support groups and networks, or they may be more formal self-help organizations that offer specific educational, recreational, social or other program opportunities.

- Direct staff hours: The number of staff hours spent by staff in providing case management services face-to-face or by telephone directly to Consumers or collaterals.
- Indirect staff hours: The number of staff hours spent by staff in providing case management services on behalf of Consumers other than face-to-face or by telephone directly with Consumers or collaterals.

Units of Service: Count the number total number of staff hours (combine direct and indirect

2810 – Case Management Service Dollars Administration
(Non-Licensed Program)

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.

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 Program)

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. 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: Count the number of recipients utilizing these funds.

2990 - Coordinated Children's Services Initiative
(Non-Licensed Program)

The Coordinated Children's Services Initiative (CCSI) is an interagency initiative that supports localities in creating a system of care to provide structure and flexibility to ensure that children who are at risk of residential placement remain at home with their families and in their communities. The program exists at a local community level (Tier I), County level (Tier II) and State level (Tier III). These children are most often those with serious emotional disturbance. Principles are based on the Child and Adolescent Services System.

Units of Service: Count the total number of paid staff hours.

3010 – Inpatient Psychiatric Unit of a General Hospital
(Licensed Program)

A licensed, 24 hr. inpatient treatment program, that is jointly licensed by the New York State Office of Mental Health and the New York State Department of Health and operated in a medical hospital. Includes full-time medical, psychiatric and social services and around-the-clock nursing services for individuals with mental illness.

Units of Service: Count one patient day as one unit.

3040 – Home-Based Crisis Intervention
(Non-Licensed Program)

The Home-Based Crisis Intervention Program is a clinically oriented program with support services by a MSW or Psychiatric Consultant which assists families with children in crisis by providing an alternative to hospitalization. Families are helped through crisis with intense interventions and the teaching of new effective parenting skills. The overall goal of the program is to provide short-term, intensive in-home crisis intervention services to a family in crisis due to the imminent risk of their child being admitted to a psychiatric hospital. The target population for the HBCI Program is families with a child or adolescent ages 5 to 17 years of age, who are experiencing a psychiatric crisis so severe that unless immediate, effective intervention is provided, the child will be removed from the home and admitted to a psychiatric hospital. Families referred to the program are expected to come from psychiatric emergency services.

Units of Service: Total number of paid staff hours.

3070 - Shelter Plus Care Housing
(Non-Licensed Program)

A federally-funded program of housing assistance specifically targeted to the homeless mentally ill. Funds may be used for the payment of rent stipends up to the federally-established Fair Market rent, and associated administrative expenses. OMH requires any not-for-profit agency in receipt of these funds to report the funds in a separate program column. Shelter Plus Care Grants are made for five or ten years at a time. Renewals are for one year only. This program code is used in cases where the federal funds flow through OMH. In cases where the funds do not flow through OMH, see Program Code 2070.

Units of Service: Not applicable.

3130 – CPEP Crisis Intervention
(Licensed Program)

This licensed, hospital-based psychiatric emergency program establishes a primary entry point to the mental health system for individuals who may be mentally ill to receive emergency observation, evaluation, care and treatment in a safe and comfortable environment. Emergency visit services include provision of triage and screening, assessment, treatment, stabilization and referral or diversion to an appropriate program. Brief emergency visits require a psychiatric diagnostic examination and may result in further CPEP evaluation or treatment activities, or discharge from the CPEP program. Full emergency visits, which result in a CPEP admission and treatment plan, must include a psychiatric diagnostic examination, psychosocial assessment and medication examination. Brief and full emergency visit services are Medicaid reimbursable.

CPEP Crisis Intervention is one of four program components which, when provided together, form the OMH licensed Comprehensive Psychiatric Emergency Program (CPEP), and the code to which the license is issued. The other program components of the CPEP are: CPEP Extended Observation Beds (1920), CPEP Crisis Outreach (1680) and CPEP Crisis Beds (2600).

Units of Service:
- Brief Emergency Visit
- Full Emergency Visit

Count the total number of visits.

3340 - Work Program
(Non-Licensed Program)

The objective is to provide vocational assessment, training and transitional or long-term paid work in institutional or community job sites for individuals disabled by mental illness. Paid by the vocational services provider.

Units of Service: Count the total number of staff hours.

3990 - Multicultural Initiatives
(Non-Licensed Program)

Funds will support activities related to the development and operation of outreach interventions in under-served communities and to address disparities based upon culture, ethnicity, age, or gender. Efforts by service providers will include the cultural and linguistic competence of their programs, management and staff.

Units of Service: Count the total number of staff hours.

4040 – Teaching Family Home
(Licensed Program)

The Teaching Family Homes are designed to provide individualized care to children and youth with serious emotional disturbances in a family-like, community-based environment. Specially trained parents live and work with four children and youth with serious emotional disturbances in a home-like setting. The teaching parents are responsible for the social education of the children and the implementation of a service plan developed in conjunction with the family and clinical service provider. The focus in on teaching the youth to live successfully in a family, attend school, and live productively in the community.
This is a type of Licensed Housing/Community Residential program for children and adolescents as defined in 14NYCRR594.

Units of Service: Count each resident day.

4340 - Ongoing Integrated Supported Employment Services
(Non-Licensed Program)

These funds are intended for ongoing job maintenance services including job coaching, employer consultation, and other relevant supports needed to assist an individual in maintaining a job placement. These services are intended to complement VESID time-limited supported employment services.

Units of Service: Count the total number of staff hours.

5070 – Supported Single Room Occupancy (SP-SRO)
(Non-Licensed Program)

A single-room occupancy residence which provides long term or permanent housing in a setting where residents can access the support services they require to live successfully in the community. Front desk coverage is provided 24 hours per day. Mental health service supports are provided either by SP-SRO staff or non-residential service providers in accordance with a service plan developed jointly by the provider and resident.

Units of Service: Resident day.

5340 - Supported Education
(Non-Licensed Program)

The objective of this program is to provide mental health and rehabilitation services to individuals with a serious mental illness to assist them to develop and achieve academic goals in natural and community-based educational settings. The emerging program models for delivering this service include free-standing career-development and exploration programs housed on college campuses, ongoing counseling and support by a mental health provider to enrolled students, and collaborative relationships between mental health and on-campus services to students with disabilities. Funding is to cover mental health staff and related costs.

Units of Service: Count the total number of paid staff hours.

5990 – MICA Network
(Non-Licensed Program)

The proposed network must define a service area, a target population and ensure that MICA Consumers have access to housing, treatment, peer support/self-help and alcohol/substance abuse services and case management. A MICA Network would include, but not be limited to: residential capacity, case management, psycho-social capacity, enhancement of treatment capacity, self-help, peer leadership/peer specialist/peer case management, linkages with drug and alcohol providers.

Units of Service: Count the total number of paid staff hours.

6050 - Supported Housing Rental Assistance
(Non-Licensed Program)

Rental assistance is provided to residents of supported housing programs through the means of a voluntary agency-administered rent stipend mechanism. Residents are expected to contribute 30% of their income toward

the cost of rent and utilities in decent, moderately priced housing in the community; the difference between the residents' contribution and the actual cost of the housing is paid directly to the landlord on behalf of the program residents.

Units of Service: Count one resident day as one unit.

6060 - Supported Housing Community Services
(Non-Licensed Program)

This includes all services provided to residents of supported housing programs by the supported housing agency, excluding rental assistance. The objective of the program is to assist individuals in locating and securing housing of their choice and in accessing the supports necessary to live successfully in the community. Services may include assistance with choosing housing, roommates, and furniture; providing financial assistance with purchasing apartment furnishings and with initial apartment/utility deposits, assistance with resolving roommate or landlord issues that may jeopardize the stability of the housing placement; and linking residents to a comprehensive community support system of case management, mental health and general health supports.

Units of Service: Count each contact as one unit.

6070 – Treatment Congregate
(Licensed Program)

A group-living designed residential program which focuses on interventions necessary to address the specific functional and behavioral deficits which prevent residents from accessing generic housing. These interventions are goal-oriented, intensive, and usually of limited duration. Staff is on-site 24 hours/day.
This is a type of Licensed Housing/Community Residential program for adults as defined in 14NYCRR595.

Units of Service: Count one resident day as one unit.

6080 – Support Congregate
(Licensed Program)

A single-site residential program which provides support designed to improve or maintain an individual's ability to live as independently as possible and eventually access generic housing. Interventions are provided consistent with the resident's desire, tolerance and capacity to participate in services. Staff is on-site 24 hours/day.

Units of Service: Count one resident day as one unit.

6110 – Community Residence for Eating Disorder Integrated Treatment Program (CREDIT)
(Licensed Program)

Community Residence for Eating Disorder Integrated Treatment Program (CREDIT) is a subclass of community residence program for either children and adolescents ages 12-18 or for adults over age 18 who have been diagnosed with an eating disorder; whose individual treatment issues preclude family settings or other less restrictive alternatives. A CREDIT program in addition to the requirements for licensed residential programs also must be affiliated with an entity designated by the New York State Department of Health as a

Comprehensive Care Center for Eating Disorders (CCCED). This program receives no state funding and is not approved to bill Medicaid. This program is described in the OMH regulations Parts 594 and 595.

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 total number of PROS units provided, rounded to the nearest whole number. The calculation of PROS units is described in 14 NYCRR Part 512.

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 and Adult Home SCM is set at a case manager client ratio of 1:30. Medicaid billing requires a minimum of two 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
(Non-Licensed Program)

In addition to the program description for Targeted Case Management located in the Spending Plan Guidelines, SCM is provided to adult home residents by Supportive Case Managers who work as a team 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 for 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 Program)

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 purchased on behalf of a recipient, such as Respite or Crisis Services, should be reported using the appropriate Service Dollar program code. SCM Service Dollars may only be used on recipients receiving BCM, ICM, SCM or ACT Services and cannot be used for any other purpose. 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: Count the number of recipients utilizing these funds.

6920 - Adult Home Service Dollars
(Non-Licensed Program)

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. Adult Home Service Dollars may only be used on recipients receiving AHSCM Services and cannot be used for any other purpose. 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: 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.

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 total number of PROS units provided, rounded to the nearest whole number. The calculation of PROS units is described in 14 NYCRR Part 512.

8050 - Community Residence Single Room Occupancy (CR-SRO)
(Licensed Program)

The single room occupancy residence which provides long-term housing where residents can access the support services they require to live successfully in the community and to eventually move to other residential settings. Front desk coverage is provided 24 hours per day. Mental health services are provided either by program staff or non-residential service providers, according to a plan which is developed jointly by the provider and resident.

Individuals may remain in residence as long as the services provided in the program are needed.

This is a type of Licensed Housing/Community Residential program for adults as defined in 14NYCRR595.

Units of Service: Count one resident day as one unit.

8340 - Limited License PROS
(Licensed Program)

Personalized Recovery Oriented Services (PROS) is a comprehensive recovery oriented program for individuals with severe and persistent mental illness. The goal of the program is to integrate treatment, support and rehabilitation in a manner that facilitates the individual's recovery. Goals for individuals in the program are to: improve functioning, reduce inpatient utilization, reduce emergency services, reduce contact with the criminal justice system, increase employment, attain higher levels of education and secure preferred housing. A Limited License PROS program provides only Ongoing Rehabilitation and Support (ORS) and Intensive Rehabilitative Services (IR).

Units of Service: Count the total number of PROS units provided, rounded to the nearest whole number. The calculation of PROS units is described in 14 NYCRR Part 512.

8810 – Assertive Community Treatment (ACT) Service Dollars
(Non-Licensed Program)

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. ACT Service Dollars may only be used on recipients receiving BCM, ICM, SCM or ACT Services and cannot be used for any other purpose. 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: 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.

Below is an alphabetical listing of program types and the corresponding codes. Following this alphabetic list is a numeric list of program definitions and the corresponding codes.

Program Name	Program Code
Assistive Technology Administration (Pilot)	0256
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
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 Community Habilitation (Services on or after 11/1/10)	0237
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	0227
HCBS Residential Habilitation Service (At Home) (Pre 11/1/10 Services)	0236
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
Home Care	0630
ICF/DD (Over 30 Beds)	1090
ICF/DD (30 Beds or Less)	0090
Individualized Support Services	0410
Information & Referral	0750
Learning Institute	0418
Local Governmental Unit (LGU) Administration	0890
Medicaid Service Coordination	0229
OPWDD Part 679 Clinic Treatment Facility (Article 16 Clinic)	0100

Program Name	Program Code
OPWDD Part 679 Clinic Treatment Facility (Article 16 Clinic Joint Venture)	0101
OPWDD Part 680 Specialty Hospital	0121
Options for People Through Services (NYS OPTS)	0234
Portal	0417
Preschool Program	0370
Program Development Grants and Start-Up	0190
Recreation and/or Fitness	0610
Residential Reserve for Replacement (RRR) – ICF/DD (30 Beds or Less)	0295
Residential Reserve for Replacement (RRR) – ICF/DD (Over 30 Beds)	0296
Residential Reserve for Replacement (RRR) – Supervised IRA	0297
Residential Reserve for Replacement (RRR) – Supportive IRA	0298
Residential Reserve for Replacement (RRR) – OPTS	0299
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 Training	5090
VOICF/DD, Day Training (Not Operated by Service Provider)	5091
VOICF/DD, School District Contract	3090
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

0060 - Crisis Intervention

Note: This program code is not to be used to report Family Support Services contracts. Use Program Code 0150 to report all Family Support Services contracts.

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

Note: This program code is not to be used to report Family Support Services contracts. Use Program Code 0150 to report all Family Support Services contracts.

A program certified by the Department of Health in accordance with sub-part 7-2 of Chapter 1 of the State Sanitary Code (Title X NYCRR) which provides overnight accommodations for periods of occupancy of more than 48 continuous hours. Such camps provide for the physical needs of campers and also implement a program of organized activities for the purpose of recreation and enhancement of the intellectual, sensorimotor and effective development of the participants.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent.

The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: For each unit of service, count one participant day.

For Budget Format: Count each participant day as one day.

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.

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.

If this program code is reported, a corresponding OPWDD-1, ICF/DD Schedule of Service, must be completed.

Notes:

- When the ICF/DD rate includes an add-on component for an ICF/DD School contract and the provider operates both the School and VOICF/DD programs, report all expenses and revenue in a discreet column as Program Code 3090. If the School and VOICF/DD programs are not operated by the same provider, report the liability associated with the add-on on CFR-1, line 68c. The increase revenue for this service that was added to the

VOICF/DD rate should be reported as Medicaid in the related ICF/DD program. See Section 13.0, line 68c, for additional details.

- 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 or Program Code 6091 as appropriate.
- Add-on for VOICF/DD, Day Services - When VOICF/DD consumers attend a Day Service program, the associated liability related to this add-on is to be reported on CFR-1, line 68d. The increase revenue for this service that was added to the VOICF/DD rate should be reported as Medicaid in the related ICF/DD program. See Section 13.0, line 68d, for additional details.

Do not include Day Treatment, HCBS Day Habilitation or HCBS Prevocational 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.

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 Part 679 Clinic Treatment Facility (Article 16 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) away from 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 the clinic's main site, a certified satellite site and off-site services, should be included in one column.

Units of Service: Units of Service as defined (Part 679.5) as a clinic visit delivered at the main certified site, or at a certified satellite site or off-site. There is reimbursement claimed for only one (1) clinic visit per day per person or his/her collateral regardless of the number, types or locations of service(s) provided.

0101 – OPWDD Part 679 Clinic Treatment Facility (Article 16 Clinic Joint Venture)

A Clinic Joint Venture is defined as a Voluntary operated Part 679 Clinic Treatment Facility (Article 16 clinic) 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 certified satellite site and any other additional certified satellite site 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) as a clinic visit delivered at the main certified site, or at a certified satellite site or off-site. There is reimbursement claimed for only one (1) clinic visit per day per person or his/her collateral regardless of the number, types or locations of service(s) provided.

0120 - Specialty Clinic

Intensive diagnosis and/or medically prescribed treatment services provided during day and/or evening hours to 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.

0121 – OPWDD Part 680 Specialty Hospital

A certified facility, including program services and physical site, that is designed as the most intensive provider of care for persons with developmental disabilities and health care problems through an integrated combination of assessment services, active programming, continuing medical treatment and residential arrangements. Specialty hospital services include mandatory and selective services. Mandatory services are provided daily to all persons residing in a specialty hospital by the staff of a

specialty hospital. Selective services may be provided either by the staff of a specialty hospital or through written agreements by staff of contract agencies.

Operating costs are a facility's costs, other than capital costs or start-up costs that include personal service costs, administrative and general services costs, and other than personal service (OTPS) costs.

Reimbursable costs are actual or budgeted costs that are determined allowable based on a line item review/desk audit process by OPWDD or Blue Cross/Blue Shield of Greater New York.

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.

Unit of Service: Unit of Measure defined (Part 680.12) as a client day, including lodging and services rendered to one person between the census-taking hours of the facility on two successive days; the day of admission but not the day of discharge is counted. One client day is counted if the person is discharged on the same day that the person is admitted, providing that there was an expectation that the admission would have been at least 24-hour duration.

0150 - Family Support Services

Those services other than basic residential and habilitative services needed by people with developmental disabilities to sustain themselves in appropriate community settings. They also include those services that families with disabled members need to provide environmental supports and maintenance of family stability and integrity. Family Support Services typically include information and referral, parent training, family counseling, recreation, home-based care, adaptive equipment and home modification, and legal services.

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 and Start-Up

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. Include the name and address of the site that is being developed. Include the operating certificate, if known, as the Program/Site Identification Number. It the operating certificate number is not known, create a Program/Site Identification Number by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Note: See Appendix P for more detailed information regarding Program Development Grants and Start-ups.

Units of Service: Not applicable.

0200 - Day Treatment Free Standing

A planned combination of diagnostic, treatment, and rehabilitative services provided to developmentally disabled individuals in need of a broader range of services than those provided in clinic treatment programs. Persons provided day treatment will attend regularly for periods in excess of three hours. Day Treatment Programs may vary widely in the services offered, the level of disability of participants, the staffing plan, the program goals and the types and numbers of cooperative agency relationships.

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the site's Operating Certificate Number as the Program/Site Identification Number.

Revenue for transportation to and from Day Treatment should be reported as "Transportation, Medicaid" (CFR-1, Line 76) for Medicaid eligible consumers and/or "Transportation, Other" (CFR-1, Line 77) for non-Medicaid eligible consumers.

See Program Codes 0670 and 0880 for specifics on reporting expenses regarding transportation to and from Day Treatment.

Note: Do not include Day Treatment 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.

Note: Count each visit, whether half-day or full-day, as 1 unit of service. There are no half units of service.

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

Note: This program code is not to be used to report the Enhanced Supported Employment contract. Use Program Code 0234 (12) to report the Enhanced Supported Employment contract.

Supported Employment services assist people in finding and keeping employment that the person finds meaningful. It provides appropriate staff and/or supports to help individuals obtain and maintain paid employment. The service takes place in integrated work settings in the community, which

provide opportunities for regular interactions with individuals who do not have disabilities and who are not paid to provide services to people with a developmental disability.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Units of Service: One month of service equals one unit of service.

0215 - HCBS Environmental Modifications

Selected internal and external changes to the person's physical home environment, required by the person's individualized service plan, which are necessary to ensure the health, welfare and safety of the person of which enable him or her to function with greater independence in the home and without which the person would require institutionalization. Environmental modifications will be provided on a limited one-time only basis to the extent necessary to enable people with physical infirmities and disabilities to live safely in community homes outside the institutional setting. Report all similar services as one program/site. The revenue is reported as Medicaid.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

100% of Environmental Modification cost is to be reported as Equipment or Property-Other as appropriate. If property or equipment belongs to the service provider, the cost will be depreciated on the service provider's books and will be a reconciling item since 100% of the cost is reported in the first year.

Units of Service: Not applicable.

0216 - HCBS Adaptive Technologies

The provision of devices, aids, controls, appliances or supplies of either a communication or adaptive type determined necessary to enable the person to increase his or her ability to function in a home and community based setting with independence and safety. The aid, whether of a communication or adaptive type, must be documented in the person's individualized service plan as being essential to the person's habilitation, ability to function or safety, and essential to avoid or delay more costly institutional placement. Report all similar services as one program/site. The revenue is reported as Medicaid.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Units of Service: Not applicable.

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 include 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.

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 HCBS Group 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

Note: Count each half unit as .5 and each full unit as 1.0. Add the sum of half units to the sum of full units to get the total units of service for this program. If the total units of service include a decimal, please round up.

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 Supplemental 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 HCBS Supplemental Group 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

Note: Count each half unit as .5 and each full unit as 1.0. Add the sum of half units to the sum of full units to get the total units of service for this program. If the total units of service include a decimal, please round up.

0225 - HCBS Individual Day Habilitation Service

HCBS day habilitation provides assistance with acquisition, retention or improvement of self-help, socialization and adaptive skills. Individual Day Habilitation services are provided with a staff-to-consumer ratio of no greater than one consumer per staff member and are delivered on weekdays and have a service start time prior to 3:00 p. m.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Revenue for transportation to and from HCBS Individual 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 HCBS Individual 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 Supplemental Individual 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 HCBS Supplemental Individual Day Habilitation To/From Transportation expense in this program. If a vehicle or staff person is assigned to this program, but is used for to/from transportation, the related expenses must be reported under Program Code 0670. See Program Code 0670 for instructions on reporting and allocating these expenses.

Units of Service: Report using billable units (i.e.: one quarter hour equals one unit of service).

0227 - HCBS Prevocational Services

Services 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.

Revenue for transportation to and from HCBS Prevocational Services 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 Prevocational Services.

Note: Do not include HCBS Prevocational 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 or more hours with at least two face-to-face services

Note: Count each half unit as .5 and each full unit as 1.0. Add the sum of half units to the sum of full units to get the total units of service for this program. If the total units of service include a decimal, please round up.

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. Revenue is reported as Medicaid for Medicaid eligible individuals or as "Other Revenue" for non-Medicaid eligible individuals.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Units of Service: One month of service equals one unit of service.

0231 - HCBS Supervised IRA (Room and Board and Residential Habilitation Services)

A Supervised IRA has staff onsite or proximately available at all times when the individuals are present.

Report expenses for both Room and Board and Residential Habilitation Services. This includes assistance with acquisition, retention or improvements of self-help skills related to activities of daily living, such as personal grooming and cleanliness, bed-making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Residential habilitation services are provided in the person's place of residence. Do not include any expenses for programming provided as day habilitation. Do not include expenses for Residential Habilitation Services or Room and Board for HCBS Supportive IRAs or Part 671 Community Residences (Supervised or Supportive).

Program type reporting is required for this program. All program site expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Note: Do not include Day Treatment, HCBS Day Habilitation or HCBS Prevocational 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:
Half-month: Minimum of 11 enrollment days in the calendar month but less than 22 enrollment days
Full-month: Minimum of 22 enrollment days in the calendar month

Note: Count each half unit as .5 and each full unit as 1.0. Add the sum of half units to the sum of full units to get the total units of service for this program. If the total units of service include a decimal, please round up.

0232 - HCBS Supportive IRA (Room and Board and Residential Habilitation Services)

A Supportive IRA provides practice in independent living under variable amounts of oversight delivered in accordance with the individual's needs for supervision. Staff typically are not onsite nor proximately available at all times when the individuals are present.

Report expenses for both Room and Board and Residential Habilitation Services. This includes assistance with acquisition, retention or improvements of self-help skills related to activities of daily living, such as personal grooming and cleanliness, bed-making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting.

Residential habilitation services are provided in the person's place of residence. Do not include any expenses for programming provided as day habilitation. Do not include expenses for Residential Habilitation Services or Room and Board for HCBS Supervised IRAs or Part 671 Community Residences (Supervised or Supportive).

Program type reporting is required for this program. All program site expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Note: Do not include Day Treatment, HCBS Day Habilitation or HCBS Prevocational 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:
Half-month: Minimum of 11 enrollment days in the calendar month but less than 22 enrollment days
Full-month: Minimum of 22 enrollment days in the calendar month

Note: Count each half unit as .5 and each full unit as 1.0. Add the sum of half units to the sum of full units to get the total units of service for this program. If the total units of service include a decimal, please round up.

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. Use the site's Operating Certificate Number as the Program/Site Identification Number.

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 Hab
- 06 Individual Day Hab
- 07 Pre-Vocational
- 08 Blended DP
- 09 At-Home Res Hab
- 10 Hourly Respite
- 11 Free Standing Respite
- 12 Monthly Supported Employment (SEMP, including Enhanced Supported Employment)
- 13 Family Care
- 18 Supplemental Group Day Hab
- 19 Blended DPS
- 20 Blended PS
- 22 General DD-Hourly
- 23 General DD-Per Diem
- 24 General DD-Monthly
- 25 Supplemental Individual Day Hab
- 26 General DD-Per Unit
- 27 Blended DS
- 28 Community Habilitation
- 29 Product Fee
- 30 Intensive Behavioral
- 99 Other

Note: For NYS OPTS approved contracts for the Day Habilitation and Pre-Vocational Service Types: revenue for transportation to and from Day Habilitation and Pre-Vocational Services 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 or Pre-Vocational To/From Transportation expenses in these programs. If a vehicle or staff person is assigned to these programs, but are 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 and Prevocational Services.

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.)

0236 - HCBS Residential Habilitation Service (At Home) (Pre 11/1/10 Services)

Residential habilitation services are provided to individuals who live in their own home or family home (i.e., the person cannot live in a certified residence). Services must start at the home or stop at the home or be delivered entirely at the home. Services may include assistance with acquisition, retention or improvements of self-help skills related to activities of daily living, such as personal grooming and cleanliness, bed-making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Do not include any expenses for programming provided as day habilitation.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Units of Service: Report using billable units. (i.e.: one quarter hour equals one unit of service.)

0237 - HCBS Community Habilitation Service (Services on or after 11/1/10)

Residential habilitation services are provided to individuals who live in their own home or family home (i.e., the person cannot live in a certified residence). Services may include assistance with acquisition, retention or improvements of self-help skills related to activities of daily living, such as personal grooming and cleanliness, bed-making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Do not include any expenses for programming provided as day habilitation.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Units of Service: Report using billable units. (i.e.: one quarter hour equals one unit of service.)

0256 – HCBS Assistive Technology Administration (Pilot)

Note: Any individual contracts for Environmental Modifications or Adaptive Technologies the voluntary agency may enter into with the local DDSO for consumers living in residential facilities operated by the voluntary agency should be reported under Program Code 0215 or Program Code 0216 as appropriate.

Only voluntary agencies that have contracts with their local DDSO that allow them to administer Environmental Modifications and Adaptive Technologies contracts with consumers and families should report under this program code.

100% of the individual payments made by the voluntary agency to consumers or families to reimburse them for the actual cost of environmental modifications and/or the adaptive technologies covered under the contract should be aggregated and reported as OTPS-Other using the description "Assistive Technology

Payments to Consumers/Families." Program and/or agency administrative costs incurred by the voluntary agency to oversee the environmental modification and/or the adaptive technology contracts should be reported on the applicable personal service, fringe benefit and/or OTPS line. The revenue should be reported as Medicaid.

Program type reporting is required for this program. The revenues and expenses for all assistive technology provisions (Environmental Modifications or Adaptive Technologies) administered by the voluntary agency should 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

0295 – Residential Reserve for Replacement (RRR) – ICF/DD (30 Beds or Less)

Report all expenses, exclusive of personal service or fringe benefits, directly related to Residential Reserve for Replacement (RRR) funding for the ICF/DD site in this column. (If provider staff complete the renovations, their wages and benefits cannot be funded from the RRR. They should be reported under the related ICF/DD site.) Only the cost of the actual renovation (e.g., depreciation, interest on loans) should be reflected in the RRR column using all applicable lines. The standard rules for depreciating and expensing will apply for reporting RRR expenses.

Revenue should not be reported in the RRR column. Report the RRR revenue in the related ICF/DD column on the same line that the revenue is reported for that program: CFR-1, Line 72 – Medicaid or Line 94 – Other Revenue.

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: Not Applicable

0296 - Residential Reserve for Replacement (RRR) – ICF/DD (Over 30 Beds)

Report all expenses, exclusive of personal service or fringe benefits, directly related to Residential Reserve for Replacement (RRR) funding for the ICF/DD site in this column. (If provider staff complete the renovations, their wages and benefits cannot be funded from the RRR. They should be reported under the related ICF/DD site.) Only the cost of the actual renovation (e.g., depreciation, interest on loans) should be reflected in the RRR column using all applicable lines. The standard rules for depreciating and expensing will apply for reporting RRR expenses.

Revenue should not be reported in the RRR column. Report the RRR revenue in the related ICF/DD column on the same line that the revenue is reported for that program: CFR-1, Line 72 – Medicaid or Line 94 – Other Revenue.

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: Not Applicable

0297 - Residential Reserve for Replacement (RRR) – Supervised IRA

Report all expenses, exclusive of personal service or fringe benefits, directly related to Residential Reserve for Replacement (RRR) funding for Supervised IRA programs in this column. (If provider staff complete the renovations, their wages and benefits cannot be funded from the RRR. They should be reported under the Supervised IRA program.) Only the cost of the actual renovation (e.g., depreciation, interest on loans) should be reflected in the RRR column using all applicable lines. The standard rules for depreciating and expensing will apply for reporting RRR expenses.

Revenue should not be reported in the RRR column. Report the RRR revenue in the Supervised IRA column, on the same line that the revenue is reported for that program: CFR-1, Line 72 – Medicaid or Line 94 – Other Revenue.

Program type reporting is required for this program. All program sites expenses 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

0298 - Residential Reserve for Replacement (RRR) – Supportive IRA

Report all expenses, exclusive of personal service or fringe benefits, directly related to Residential Reserve for Replacement (RRR) funding for Supportive IRA programs in this column. (If provider staff complete the renovations, their wages and benefits cannot be funded from the RRR. They should be reported under the Supportive IRA program.) Only the cost of the actual renovation (e.g., depreciation, interest on loans) should be reflected in the RRR column using all applicable lines. The standard rules for depreciating and expensing will apply for reporting RRR expenses.

Revenue should not be reported in the RRR column. Report the RRR revenue in the Supportive IRA column, on the same line that the revenue is reported for that program: CFR-1, Line 72 – Medicaid or Line 94 – Other Revenue.

Program type reporting is required for this program. All program sites expenses 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

0299 - Residential Reserve for Replacement (RRR) – OPTS

Report all expenses, exclusive of personal service or fringe benefits, directly related to Residential Reserve for Replacement (RRR) funding for approved contracts established under the NYS OPTS program. (If provider staff complete the renovations, their wages and benefits cannot be funded from the RRR. They should be reported under the residential portion of the related OPTS contract.) Only the cost of the actual renovation (e.g., depreciation, interest on loans) should be reflected in the RRR columns using all applicable lines. The standard rules for depreciating and expensing will apply for reporting RRR expenses.

Revenue should not be reported in the RRR columns. Report the RRR revenue in the related residential OPTS column on the same line that the revenue is reported for that program; Line 75 – OMRDD Residential Room and Board/NYS OPTS.

Service Type reporting is required for this program. When RRR funding is included in an OPTS contract, there must be a separate column on the CFR to report the related RRR expenses. 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 (01 - Supervised IRA with Res Hab or 02 - Supportive IRA with Res Hab) as the index code.

Units of Service: Not Applicable

0330 - Day Training

A program or planned combination of services provided to developmentally disabled persons whose level of disability is not so severe as to require day treatment services but whose functional behavior deficits limit their ability to function independently. The goal of day training programs is to provide program interventions that will assist developmentally disabled persons in the acquisitions of knowledge and skills that will enable them to improve their personal, social, and vocational skills and their ability to function independently. Day training also includes programs consisting of specialized developmental services that are operated with the goal of providing developmentally disabled persons with habilitation and social skills which will enable the individual to maintain gains made in other programs or to gain entry to a level of programming requiring more independent functioning. The program may operate as a complement to other day programs or on an intermittent basis to accommodate gaps in regular programs. Included here could be afternoon, evening or weekend programs operated by service providers who operate other day services. The emphasis of these programs is on the maintenance of existing skills and the development of social, recreational, and leisure activities which are intellectually and interpersonally stimulating and augment health maintenance. This may include recreational, music movement and art activities as indicated in the participant's program plan.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service:
Less than half-day visit: Less than 3 hours = .30
Half-day visit: 3 but less than 5 hours = .50
Full-day visit: 5 hours or more = 1.00
For Budget Format: Count each visit as one visit.

0340 - Certified Work Activity/Sheltered Workshop

A program certified by the U.S. Department of Labor and 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.

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

Note: This program code is not to be used to report Family Support Services contracts. Use Program Code 0150 to report all Family Support Services contracts.

A program of special education services provided on a consolidated basis with diagnosis and/or rehabilitative services for 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

Note: This program code is not to be used to report Family Support Services contracts. Use Program Code 0150 to report all Family Support Services contracts.

Program which provides services to developmentally disabled individuals under the age of five. The goal of such services is to provide preventive and ameliorative services to children at risk of developmental disability diagnosis in order to prepare them for acceptance into a school program operated by the public schools. The activities of such programs would include but are not limited to pre-academic skills, social interaction skills, self care skills and infant stimulation.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: Each visit.

0380 - Transitional Employment

Note: This program code is not to be used to report Family Support Services contracts. Use Program Code 0150 to report all Family Support Services contracts.

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)

Note: Do not use this program code if billing is based on a fee. Use Program Code 0214 (HCBS Supported Employment) if billing is fee based.

Supported employment is designed for individuals who, because of the severe nature of their disabilities, require ongoing interventions and supports in order to obtain and maintain employment. It is not for those who would be better served in time limited preparations for competitive employment. The individuals must be engaged in meaningful work for wages on a full-time or part-time schedule. The employment must be in an integrated work setting providing frequent daily social interactions with people who are not disabled and who are not paid care givers. Federal guidelines suggest limiting the number of supported employees to eight per site. Supported employment exists only when there is on-going publicly financed support directly related to the maintenance of the supported employment.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: For Supported Employment programs that are funded via direct contract, report the direct care units of service. One hour of service provided to or on behalf of each consumer equals one unit of service. Direct care hours/units shall include: hours of pre-employment, hours of on-site intervention, and hours of off-site intervention, as reported on lines 17, 18 and 19 of the Individual's Quarterly Report. For further clarifications, regarding these categories, refer to the "New York State Interagency Supported Employment Program Instructions for the Individual's Quarterly Progress".

For Budget Format: Count the number of direct hours of service provided to individual participants.

0410 - Individualized Support Services

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: As per contract.

0411 – HCBS Consolidated Supports and Services

Only agencies that are authorized to provide Fiscal Management Services under their existing waiver provider agreement should report under this program code. Agencies that subcontract to a Fiscal Management Service should not use this program code. They should include this expense on CFR-2, Column 7, "Other Programs."

Program type reporting is required for this program. All expenses paid and revenues claimed by the Fiscal Management Service provider are to be aggregated and reported in one column. Expenses are reported using all applicable expense line items. Revenue is reported as Medicaid for Medicaid eligible individuals or as "Other Revenue" for non-Medicaid eligible individuals.

The Program/Site Identification Number is created using the first four digits of the agency code and the last three digits of the program code.

Units of Service: One unit of service equals one month.

0413 – HCBS Family Education and Training

HCBS Family Education and Training is training given to the families of consumers enrolled in the Home and Community Based waiver who are under 18 years of age. The purpose of family education and training is to enhance the decision making capacity of the family unit, provide orientation regarding the nature and impact of developmental disability upon the consumer and his or her family and teach them about service alternatives. Family education and training is distinct from service coordination in that the purpose is to support the family unit in understanding the coping with the developmental disability. The

information and knowledge imparted in family education and training increases the chances of creating a support environment at a home and decreases the chances of a premature residential placement outside the home.

Family education and training is given in a two hour segment twice a year. Sessions may be private or in groups of families. Any personnel knowledgeable in the topics covered may conduct the sessions. Most frequently, this will be service coordinators, but it may also include other clinicians and experts in such fields as the law and finances pertaining to disabilities.

Program type reporting is required for this program. All expenses and revenues for all program sites are to be aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

If the individual receiving the services is HCBS waiver eligible, the funding source is Medicaid. If the individual is not HCBS waiver eligible, the funding is 100% 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

Note: This program code is not to be used to report Family Support Services contracts. Use Program Code 0150 to report all Family Support Services contracts.

Services needed by developmentally disabled individuals with epilepsy to sustain themselves in appropriate community settings. Epilepsy Services typically include, but are not limited to, information and referral, counseling, case management, education and support groups.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: As per contract.

0415 – HCBS Live-In Caregiver

When a live-in personal caregiver who is unrelated to the individual receiving care provides approved services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the home or residence of the individual served may be reimbursed.

If the individual receiving the services is HCBS waiver eligible, the funding source is Medicaid. If the individual is not HCBS waiver eligible, the funding is 100% 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.

0417 – Portal

Only agencies that are designated as a Fiscal Management Services (FMS) provider should report under this program code.

Program type reporting is required for this program. All expenses paid and revenues claimed by the Fiscal Management Services (FMS) provider 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/services or as "Other Revenue" for non-Medicaid eligible individuals/services.

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: Not Applicable

0418 – Learning Institute

Only agencies that are authorized to provide Fiscal Management Services under their existing waiver provider agreement should report under this program code. Agencies that subcontract to a Fiscal Management Service should not use this program code. They should include this expense on CFR-2, Column 7, "Other Programs."

Program type reporting is required for this program. All expenses paid and revenues claimed by the Fiscal Management Services (FMS) provider 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/services or as "Other Revenue" for non-Medicaid eligible individuals/services.

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: Not Applicable

0610 – Recreation and/or Fitness

Note: This program code is not to be used to report Family Support Services contracts. Use Program Code 0150 to report all Family Support Services contracts.

A program of social, recreational, leisure and/or fitness activities that is intellectually, interpersonally and/or physically stimulating which can be but is not necessarily part of a goal-based program plan. Agencies which provide no other types of programs should report this service in this category. Recreation and/or fitness activities which are part of other programs should not be reported as part of this recreation program.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: Each visit.

For Budget Format: Count each visit as one visit.

0630 – Home Care

Note: This program code is not to be used to report Family Support Services contracts. Use Program Code 0150 to report all Family Support Services contracts.

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 home care 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 Treatment, Day Habilitation or Prevocational Services.

Service providers who operate their own transportation cost center should report under this program code, as follows:

Revenue: Revenues reported under Program Code 0670 are to be aggregated and reported in one column.

The only revenues that should be reported under Program Code 0670 are those revenues received by the reporting agency from billing another agency for the transportation of the other agency's consumers. Transportation revenue included in a rate, fee or price should not be reported under Program Code 0670. Transportation revenue included in a rate, fee or price should be reported in the appropriate program/site.

Expense: Expenses reported under Program Code 0670 are to be aggregated and reported in one column on the appropriate expense lines (Depreciation – Equipment, Interest – Vehicle, etc.) of Schedule CFR-1.

The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

For each program/site operated by your agency for which other than to and from Day Treatment, HCBS Day Habilitation or HCBS Prevocational 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, HCBS Day Habilitation or HCBS Prevocational 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:

For transportation associated with rate based programs: 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.

For transportation associated with Aid to Localities (State Aid) funded programs: a one way trip equals 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.

0810 - Case Management (Non-Medicaid)

Note: This program code is not to be used to report Family Support Services contracts. Use Program Code 0150 to report all Family Support Services contracts.

Case management - Activities aimed at linking the patient to the service system and at coordinating the various services in order to achieve a successful outcome. The objective of case management in a mental health system is continuity of care and service. Services may include linking, monitoring and case-specific advocacy.

Linking - The process of referring or transferring a patient to all required internal and external services that include the identification and acquisition of appropriate service resources.

Monitoring - Observation to assure the continuity of service in accordance with the patient's treatment plan.

Case-Specific Advocacy - Interceding on behalf of a patient to assure to services required in the individual service plan. Case management activities are expediting and coordinative in nature rather than the primary treatment services ordinarily provided by the therapist.

Case management services are provided to enrolled patients for whom staff are assigned a continuing case management responsibility. Thus, routine referrals would not be included unless the staff member making the referral retains a continuing active responsibility for the patient throughout the system of service.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service:
Direct staff hours - The number of staff hours spent by staff in providing case management services face-to-face or by telephone directly to patients or collaterals.

Indirect staff hours - The number of staff hours spent by staff in providing case management services on behalf of patients other than face-to-face or by telephone directly with patients or collaterals.

For Budget Format: Count the total number of staff hours (combine direct and indirect).

0880 - Subcontract Services

This program code is used to report all expenses associated with sub-contract provider agencies for program delivery, and for all revenues received by the reporting agency on behalf of subcontracted provider agencies.

The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Transportation Subcontracts:
For service providers that subcontract for any transportation other than to and from Day Treatment, HCBS Day Habilitation or HCBS Prevocational Services, 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, HCBS Day Habilitation or HCBS Prevocational Services, 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). **Note**: This program type is exempt from the Ratio Value allocation of agency administration.

Units of Service: Not applicable.

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.

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.

If this program code is reported, a corresponding OPWDD-1, ICF/DD Schedule of Service, must be completed.

Notes:

- When the ICF/DD rate includes an add-on component for an ICF/DD School contract and the provider operates both the School and VOICF/DD programs, report all expenses and revenue in a discreet column as Program Code 3090. If the School and VOICF/DD programs are not operated by the same provider, report the liability associated with the add-on on CFR-1, line 68c. The increase revenue for this service that was added to the VOICF/DD rate should be reported as Medicaid in the related ICF/DD program. See Section 13.0, line 68c, for additional details.
- 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 or Program Code 6091 as appropriate.
- Add-on for VOICF/DD, Day Services - When VOICF/DD consumers attend a Day Service program, the associated liability related to this add-on is to be reported on CFR-1, line 68d. The increase revenue for this service that was added to the VOICF/DD rate should be reported as Medicaid in the related ICF/DD program. See Section 13.0, line 68d, for additional details.

Do not include Day Treatment, HCBS Day Habilitation or HCBS Prevocational 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.

1091 – Temporary Use Beds (TUBS) in an Intermediate Care Facility (Over 30 Beds)

When a bed (certified or uncertified) in an ICF/DD (over 30 beds) is used as a temporary use bed, the associated revenues and expenses should be reported under this program code. (Do not report the same revenue and expense under Program Code 1090 – Intermediate Care Facility (over 30 beds).)

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the site's Operating Certificate Number as the Program/Site Identification Number.

Units of Service: One hour of service equals one unit of service.

1150 - Traumatic Brain Injury (TBI)

Those services which provide individuals with TBI and their families with information, referral, counseling, advocacy, training and emotional support. A professional approach includes intake, follow up documentation and confidentiality. In addition, outreach to schools, hospitals and other human service agencies, as well as, linkage to other professionals through client specific discussion is provided.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Units of Service: As per contract.
For Budget Format: As per contract.

1190 - Special Legislative Grants

Specific grants funded as a result of legislative member support, targeted for a particular purpose.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: Not applicable.

1220 - Care at Home - III

A Medicaid Waiver service providing financial assistance to families with children living at home who have severe disabilities or medical conditions. Parental income and resources are not considered when determining the child's eligibility for Medicaid. Medicaid services include Service Coordination, Respite Care and Assistive Technologies. For care at Home III only: the family must have applied for out-of-home residential placement for the child.

Program type reporting is required for this program. All expenses and revenues for all program sites are to be aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code

Units of Service: Not applicable.

1850 – Voluntary Preservation Project-Formerly Known as Voluntary Operated Maintenance Contract

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. The revenue is reported as Net Deficit Funding.

Units of Service: As per contract.

2090 – Voluntary Operated Intermediate Care Facility for the Developmentally Disabled, Sheltered Workshop

Sheltered Workshop services defined as part of the VOICF/DD Active Treatment Plan that are provided to VOICF/DD consumers.

When the service provider operates both the VOICF/DD and the Sheltered Workshop program, the increased portion of the rate and the associated expense are to be reported in this discreet column using the operating certificate number of the VOICF/DD as the program/site identification number. The revenue is reported as Medicaid and the expense is reported using all applicable expense line items. Do not include this revenue and expense in the column used to report the workshop program.

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the ICF/DD's Operating Certificate Number as the Program/Site Identification Number. For each Program Code 2090 column that is reported, there must be a corresponding Program Code 0090 or 1090 column reported

Units of Service: One day equals one unit of service.

2091 - Voluntary Operated Intermediate Care Facility for the Developmentally Disabled, Sheltered Workshop (Not Operated by Service Provider)

When VOICF/DD consumers attend a Sheltered Workshop program that is not operated by the service provider, the increased portion of the rate and the associated expenses are to be reported in a discreet column under Program Code 2091 (VOICF/DD, Sheltered Workshop) using the operating certificate number of the ICF/DD as the program/site identification number. Report revenue as "Medicaid" and expense as "OTPS-Other".

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the ICF/DD's Operating Certificate Number as the Program/Site Identification Number. For each Program Code 2091 column that is reported, there must be a corresponding Program Code 0090 or 1090 column reported.

Units of Service: One day equals one unit of service.

2190 - Developmental Disabilities Program Council Grants

Specific grants funded by the New York State Developmental Disabilities Program Council, targeted for a particular purpose.

Contract Budget Consistent reporting is required for this program. The same number of columns used on the Consolidated Budget Report must be used on the CFR so that reporting is consistent.

The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, the last digit of the Program/Site Identification Number is increased by one.

Units of Service: Not applicable.

2220 - Care at Home – IV & VI

A Medicaid Waiver service providing financial assistance to families with children living at home who have severe disabilities or medical conditions. Parental income and resources are not considered when determining the child's eligibility for Medicaid. Medicaid services include Service Coordination, Respite Care and Assistive Technologies.

Program type reporting is required for this program. All expenses and revenues for all program sites are to be aggregated and reported in one column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code.

Units of Service: Not applicable.

3070 - Shelter Plus Care Housing

A federally-funded program of housing assistance specifically targeted to homeless persons with disabilities and their families. Funds may be used for the payment of rent stipends up to the federally - established Fair Market rent, and associated administrative expenses. 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.

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.

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 CFR-1, line 68c 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.

4090 – State Operated Intermediate Care Facility for the Developmentally Disabled, Sheltered Workshop/Day Training

Sheltered Workshop/Day training services defined as part of the SOICF/DD Active Treatment Plan that are provided to SOICF/DD consumers via a contract. The revenue and the associated expense is to be reported in this discreet column using the operating certificate number of the day training program as the program/site identification number. The revenue is reported as Medicaid and the expense is reported using all applicable expense line items. Do not include this revenue and expense in the column used to report the day training program.

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the Operating Certificate Number of the day training program as the Program/Site Identification Number.

Units of Service: One day equals one unit of service.

5090 - Voluntary Operated Intermediate Care Facility for the Developmentally Disabled, Day Training

Day training services defined as part of the VOICF/DD Active Treatment Plan that are provided to VOICF/DD consumers.

When the service provider operates both the VOICF/DD and the Day Training program, the increased portion of the rate and the associated expense is to be reported in this discreet column using the operating certificate number of the VOICF/DD as the program/site identification number. The revenue is reported as Medicaid and the expense is reported using all applicable expense line items. Do not include this revenue and expense in the column used to report the day training program.

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the ICF/DD's Operating Certificate Number as the Program/Site Identification Number. For each Program Code 5090 column that is reported, there must be a corresponding Program Code 0090 or 1090 column reported.

Units of Service: One day equals one unit of service.

5091 - Voluntary Operated Intermediate Care Facility for the Developmentally Disabled, Day Training (Not Operated by Service Provider)

When VOICF/DD consumers attend a Day Training program that is not operated by the service provider, the increased portion of the rate and the associated expenses are to be reported in a discreet column under Program Code 5091 (VOICF/DD, Day Training) using the operating certificate number of the ICF as the program/site identification number. Report revenue as "Medicaid" and expense as "OTPS-Other".
Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the ICF/DD's Operating Certificate Number as the Program/Site Identification Number. For each Program Code 5091 column that is reported, there must be a corresponding Program Code 0090 or 1090 column reported.

Units of Service: One day equals one unit of service.

6090 – Day Program Services Included in the ICF/DD Reimbursement Rate (On-Site)

Day program services for ICF/DD (Program Code 0090 and 1090) consumers whose comprehensive functional assessments require that such services be delivered by the ICF/DD and the funding for these services is included in the ICF/DD rate.

When an ICF/DD has reimbursement for Day Program Services provided by the ICF/DD included in its rate, the associated expenses of the day program are to be reported in a discreet column under Program Code 6090 using the operating certificate of the ICF/DD as the program/site identification number. The revenue is reported as Medicaid and the expense is reported using all applicable expense line items. Do not report Sheltered Workshop, School District Contract, or Day Training Expenses included in an ICF/DD rate under Program Code 6090. These should be reported using Program Codes 2090, 2091, 3090, 5090 or 5091 or on CFR-1, line 68c.

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.

Note: Count each half unit as .5 and each full unit as 1.0. Add the sum of half units to the sum of full units to get the total units of service for this program. If the total units of service include a decimal, please round up.

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, 5090 or 5091 or on CFR-1, line 68c. 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.

Note: Count each half unit as .5 and each full unit as 1.0. Add the sum of half units to the sum of full units to get the total units of service for this program. If the total units of service include a decimal, please round up.

Below is a listing of SED program types with the corresponding codes in numerical order. Following this list is a numeric list of codes and the corresponding program definitions.

SED program codes require indexing. This indexing consists of a two digit field following the four digit program code. This field reflects the time frame of the information provided in each column. Below is a table of SED indexing codes:

Fiscal Year Providers		Calendar Year Providers	
Index Code	Reporting Period	Index Code	Reporting Period
YY	July – June	SS	January - June
		FF	July - December
		CC	January – December
		MM	Other

Program Name	Program Code
Shared Transportation Program	0670
School Age - Special Class	9000-9009
School Age - Special Class Half Day	9010-9014
School Age - Children's Residential Program (CRP)	9020-9021
School Age - RTF Education	9030-9038
4201 Residential Treatment Facility Education Program	9039
Preschool - Special Class - over 2.5 hours per day	9100-9109
Preschool - Special Class - 2.5 hours per day	9115-9119
Preschool - Special Education Itinerant Teacher (SEIT) Services	9135-9139
Preschool - Integrated Special Class – over 2.5 hours per day	9160-9163
ACD Funded Programs and/or Day Care costs in excess of the Integrated Program	9164
Preschool - Integrated Special Class – 2.5 hours per day	9165-9169
Preschool - Residential Program	9180-9185
Preschool – Evaluations	9190-9194
Preschool - Related Services	9200-9229
Special Education 1:1 Aides	9230
Dormitory Authority (DA)	9250
4201 State Supported Education Program	9260
4201 State Supported Residential Program	9279
Infant/Toddler - All program types	9300
4204 State Supported Deaf Infant Program (ages 0-2)	9315
Federal Grants	9800-9802 & 9804
Teacher Certification Grant	9803
Section 611 LEA Suballocation	9805
Section 619 LEA Suballocation	9806

School Age Programs (Ages 5-21)

9000-9009 - School Age-Special Class

A class consisting of school age students with the same disabilities or with differing disabilities who have been grouped together because of similar individual needs for the purpose of being provided a special education program, as defined in Sections 200.1(jj) and 200.6(g) of the Commissioner's Regulations.

9010-9014 - School Age-Special Class Half Day

A half day class consisting of school age students with the same disabilities or with differing disabilities who have been grouped together because of similar individual needs for the purpose of being provided a special education program, as defined in Sections 200.1(jj) and 200.6(g) of the Commissioner's Regulations.

9020-9021 - School Age-Children's Residential Project Education Program

A joint agency program for developmentally disabled students that accepts referrals for school age youth under the age of 18. The program consists of an SED-approved private school and a residence certified by the Office For People With Developmental Disabilities (OPWDD) as an Intermediate Care Facility for the Developmentally Disabled (ICF/DD). Admission to CRP programs is limited to those students identified through the education system as needing educational/residential services who also meet the residential eligibility criteria for the ICF/DD established by OPWDD. CRP placement options are designated for students in out-of-state programs and for students residing in New York State who are at risk of being placed out-of-state. CRP's serve both boys and girls, ages 5-21, and operate on a 12-month, 7-day a week basis.

9030-9038 - School Age-Residential Treatment Facility Education Program

Residential Treatment Facilities (RTF's), as defined in Section 4001 (7) of the Education Law, are residential programs certified by the Office of Mental Health to provide an extended level of care (beyond 180 days) for seriously emotionally disturbed students and youth between the ages of 5 and 21. Services are provided on premises to mentally ill students who require supervised, comprehensive residential mental health treatment on a 24-hour basis. This program is more intensively staffed and provides a wider range of services than community based programs, but is less restrictive than a psychiatric hospital-based program.

Preschool Programs (Ages 3 - 4)

9100-9109 - Preschool-Special Class over 2.5 hours per day

A class, approved to operate greater than 2.5 hours per day, consisting of preschool students with the same disabilities or with differing disabilities who have been grouped together because of similar individual needs for the purpose of being provided a special education program, as defined in Sections 200.1(jj) and 200.16(h)(3)(iii) of the Commissioner's Regulations.

9115-9119 - Preschool-Special Class 2.5 hours per day

A class, approved to operate 2.5 hours per day, consisting of preschool students with the same disabilities or with differing disabilities who have been grouped together because of similar needs for the purpose of being provided a special education program, as defined in Sections 200.1(jj) and 200.16(h)(3)(iii) of the Commissioner's Regulations.

9135-9139 - Preschool-Special Education Itinerant Teacher (SEIT) Services

Services provided to preschool students by a certified special education teacher on an itinerant basis at a site initially determined by the Board of Education, including but not limited to, an approved pre-kindergarten or head start program, the student's home, a hospital, a state facility, or a child care location, as defined in Section 200.16(h)(3)(ii) of the Commissioner's Regulations.

9160-9163 - Preschool-Integrated Special Class over 2.5 hours per day

A program, approved to operate greater than 2.5 hours per day, employing a special education teacher and at least one para-professional in a classroom consisting of both disabled and non-disabled preschool students or separate non-disabled and disabled classes housed in the same physical space, as defined in Section 200.9(f)(2)(x) of the Commissioner's Regulations.

9164 -- Day Care costs in excess of the Integrated Program/ACD Funded Program

Report all costs of day care in excess of the approved duration of your Integrated program. For example, if the Day Care program operates from 7 a.m. to 5 p.m. (10 hours) and the Integrated program operates from 9 a.m. to 2 p.m. (5 hours), report the costs of the 5 hours of Day Care operation in Program Code 9164. If your agency is funded by the Agency for Child Development (ACD), report all costs, revenues and related statistical data in Program Code 9164.

9165-9169 - Preschool-Integrated Special Class 2.5 hours per day

A program, approved to operate 2.5 hours per day, employing a special education teacher and at least one para-professional in a classroom consisting of both disabled and non-disabled preschool students or separate non-disabled and disabled classes housed in the same physical space, as defined in Section 200.9(f)(2)(x) of the Commissioner's Regulations.

9180-9185 - Preschool-Residential Program

A class consisting of preschool students residing in a child care institution, as defined in Section 4001(2) of the Education Law with the same disabilities or with differing disabilities who have been grouped together because of similar individual needs for the purpose of being provided a special education program.

9190-9194 - Preschool-Evaluations

Includes physical examinations, psychological examinations, social history and other suitable examinations and evaluations required to properly classify and place a child with a disability pursuant to Section 4410 of the Education Law and as defined in Section 200.16(c)(1) of the Commissioner's Regulations. Only actual costs incurred for mandated initial CPSE evaluations for 3 and 4 year old students should be reported. Indirect costs associated with the evaluations must also be reported. Evaluation cost data reported in the evaluation program cost center should not be reported in any other program cost center.

9200-9229 - Preschool-Related Services

Related services provided to preschool students by an appropriately certified or licensed individual in conjunction with a program at a facility that has been approved or licensed by an appropriate government agency including, but not limited to, pre-kindergarten, day care and Head Start programs. Such services can include, but are not limited to, speech therapy, physical therapy, occupational therapy and counseling. Professionals providing such services must be appropriately certified or licensed and must be included on the municipality's listing of related service providers. The related service must be provided at the program site unless the use of non-transportable special equipment is required to provide the related service in accordance with the child's Individualized Education Program (IEP). The site at which the related service is to be provided must be included on the IEP. (Refer to Sections 200.1(gg), 200.6(e) and 200.16(h)(3)(I) of the Commissioner's Regulations).

Infant Programs (Ages 0-2)

The infant programs listed below, funded through the Department of Health, are to be reported on the New York State Education Department (SED) schedules throughout the CFR.

9300 - Infant/Toddler - All program types

This program includes all services provided to children with disabilities who range in age from birth through two pursuant to Article 25 of the Public Health Law.

Miscellaneous

9039 - 4201 Residential Treatment Facility Education Program

A school age residential treatment facility education program run by a 4201 school.

9230 - Special Education 1:1 Aides

This cost column should include the **additional** revenue and expenses for child specific teacher aides/assistants for school age and preschool students recommended by the CSE/CPSE and included as part of the student's Individualized Education Program.

9250 - Dormitory Authority (DA)

Report revenue and expenses associated with Dormitory Authority Projects that are funded or anticipated to be funded with DA bond proceeds as authorized by Chapter 698 of the Laws of 1991, Chapter 737 of the Laws of 1988 or Chapter 407 of the Laws of 1989.

9260 - 4201 State Supported Education Program (ages 3-21)

A program consisting of preschool and school age students who are deaf, blind, physically disabled or emotionally disturbed as defined in Section 200.7 (d) of the Commissioner's Regulations.

9279 - 4201 State Supported Residential Program (ages 3-21)

A residential program, as defined in Section 200.7 (d) of the Commissioner's Regulations, for students appointed to the 4201 Education program.

9315 - 4204 State Supported Deaf Infant Program (ages 0-2)

A program consisting of children less than 3 years old who have a severe hearing loss as defined in Section 200.7 (d) of the Commissioner's Regulations. Also report any evaluation costs associated with this program.

9800-9802 & 9804 - Federal Grants

Report Federal Grant expenses and revenues administered by the State Education Department. Report each Federal Grant in a separate cost column.

Note: Effective July 1, 2006, Teacher Certification Grants are to be reported under program code 9803.

9803 – Teacher Certification Grant

State funding provided to ensure the appropriate certification of teachers in schools that provide special services or programs to preschool and school-age students with disabilities.

Note: Effective July 1, 2005, the revenues and expenses awarded by local education agencies (LEAs) pursuant to Sections 611 (g)(1) and 619 (g)(1) of the Individuals with Disabilities Education Act (IDEA) are to be reported in separate and discrete cost columns using the full accrual basis of accounting. The revenues and expenses associated §611 and §619 are to be reported under Program Codes 9805 and 9806, respectively. Previously, these funds and related expenses were direct charged or allocated to the program(s) receiving the benefit.

9805 – Section 611 LEA Suballocation

Report the revenues and expenditures awarded by local education agencies (LEAs) pursuant to the Section 611 (g)(1) of the Individuals with Disabilities Act (IDEA). This change in reporting is effective July 1, 2005 in accordance with Chapter 437 of the Laws of 2005.

9806 – Section 619 LEA Suballocation

Report the revenues and expenditures awarded by local education agencies (LEAs) pursuant to the Section 619 (g)(1) of the Individuals with Disabilities Act (IDEA. This change in reporting is effective July 1, 2005 in accordance with Chapter 437 of the Laws of 2005.

Shared Programs

0670 - Transportation

This cost column should include revenue and expenses associated with transporting students/patients/clients to and from the organization when the vehicles are not assigned to a specific program. In cases where the organization transports only individuals attending VESID programs, Program Code 9695 should be used. Staff travel, transportation for field trips, and costs associated with transporting students to and from various facilities during the day, and any other transportation costs considered allowable per the SED Reimbursable Cost Manual should be reported as a cost of the appropriate program.

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, special events costs and management services contracts provided to other entities. Costs of fundraising, special events and management services contracts are reported on Schedule 2 in Column 7 under "Other Programs".

Agency administration costs <u>do not</u> include program/site specific costs or program administration costs. **Program/site costs** are costs directly associated with the provision of services and are included on the appropriate line of expense on Schedules CFR-1 (lines 16 through 63), DMH-1 (lines 6 through 11) and DMH-2 (lines 5 through 10). **Program administration costs** are administrative costs which are directly attributable to a specific program/site (i.e., personal services and fringe benefits of Billing Personnel, Program Director, Program Coordinator, etc.) and are to be included on the appropriate line of expense on CFR-1 (lines 16 through 63), DMH-1 (lines 6 through 11) and DMH-2 (lines 5 through 10). The program administration level of administration may not be applicable to all service providers. However, all service providers must report agency administration.

County operated service providers should note that Local Governmental Unit (LGU) Administration costs are reported as a shared program using Program Code 0890 on the applicable Schedules CFR-1 through CFR-6 and DMH-1. (Refer to Appendix K.)

Service Providers should note that **all attempts should be made to directly charge an expense** to the appropriate cost center (agency administration or program/site and program administration). If you are unable to direct charge expenses to agency administration or program/site(s) and program administration, the following includes examples of recommended allocation methods:

Expense Item	Recommended Allocation Method
Repairs and Maintenance	Square Footage
Utilities	Square Footage
Staff Travel	Full-Time-Equivalents
Telephone	Number of Lines
Building Depreciation	Square Footage
Building Lease Costs	Square Footage
Mortgage Interest	Square Footage

Property Costs Relating to Agency Administrative Offices

If agency administrative offices and program offices are located in the same building, property related costs must be allocated using square footage as the statistical basis. These costs include expenses such as utilities, repairs and maintenance, depreciation, leases or mortgage interest. Square footage cost allocations must be calculated using the following procedure (square footage should be the interior square footage):

1. Determine the number of square feet which is used exclusively by agency administrative offices and each program or program/site, not shared in common.
2. Determine the number of square feet which is shared in common, i.e., lobby, restrooms, conference areas, etc.
3. Calculate an allocation ratio by dividing each exclusive square footage amount by the total amount less the commonly shared amount.
4. Multiply each respective cost by the allocation ratios to determine the allocated dollar amount.

Example: Program A and Agency Administrative Offices occupy the same building. Utility expenses of $5,000 must be allocated to Program A and to the Agency Administrative Offices as follows:

Step 1 - Exclusive square feet - Program A = 500 sq. ft.
Exclusive square feet - Agency Administrative Offices = 300 sq. ft.

Step 2 - Common square feet - 1,000 sq. ft.
Total square feet - 1,800 sq. ft.

Step 3 - Program A = 500/(1,800-1,000) = .625
Agency Administrative Offices = 300/(1,800-1,000) = .375

Step 4 - Utility expenses for this particular building total $5,000

Utility expenses allocated to Program A = $5,000 X .625 = $3,125
Utility expenses allocated to Agency Admin. Offices = $5,000 X .375 = $1,875

Property related expenses and revenues that do **NOT** pertain to your agency's DMH programs, SED programs and agency administration must be reported in the "Other Programs" Column (Column 7) of Schedule CFR-2.

Allocation of Total Agency Administration Costs to Program/Sites

To ensure equity of distribution and to provide uniformity in allocation of agency administration, OASAS, OMH, 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, 0880 and 0890. In determining the operating costs within a State Agency, the expenses for certain additional programs are deducted from the agency-wide operating costs. The resulting adjusted operating cost totals are entered on CFR-3, lines 60 through 64. Operating expenses for the following programs are to be deducted from agency-wide operating costs (CFR-3, lines 43 through 49):

- For OMH, operating expenses for programs coded 0860, 0870, 0920, 1230, 1690, 1910, 2860, 2980, 6910, 6920, 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	From Schedule *	Personal Services	Vacation Accruals	Fringe Benefits	OTPS	Equipment	Property	Total Before Administration Allocation
OASAS	CFR-1	154,000	7,700	38,500	71,000	3,200	23,000	297,400
OMH	CFR-1	230,500	11,500	57,700	185,000	2,500	18,000	505,200
OPWDD	CFR-1	840,000	4,200	210,000	425,000	7,200	55,000	1,541,400
SED	CFR-1	450,000	22,500	112,500	225,000	5,900	30,000	845,900
Shared	CFR-1	155,000	7,600	38,700	63,000	2,900	27,000	294,200
Other	CFR-2	60,000	3,000	15,000	35,000	1,500	5,800	120,300
Total		$1,889,500	$56,500	$472,400	$1,004,000	$23,200	$158,800	$3,604,400

Provider XYZ reports program/site and program administration expenses for the following OMH programs:

OMH Program	From Schedule*	Personal Services	Vacation Accruals	Fringe Benefits	OTPS	Operating costs
2100	CFR-1	230,500	11,500	57,700	110,000	409,700
1910	CFR-1	0	0	0	75,000	75,000
Total		$230,500	$11,500	$57,700	$185,000	$484,700

For this example, assume page 1 of Schedule CFR-3, Agency Administration, line 42 reflects net agency administration of $650,400. Net agency administration must be allocated to all programs using the ratio value method which is based on operating costs. Operating costs include personal services, vacation accruals, fringe benefits and OTPS (less sub-contract raw materials - CFR-1, line 29). Based on the information reported above, operating costs are calculated as follows:

Program	From Schedule*	Personal Services	Vacation Accruals	Fringe Benefits	OTPS	Operating costs
OASAS	CFR-1	154,000	7,700	38,500	71,000	271,200
OMH	CFR-1	230,500	11,500	57,700	185,000	484,700
OPWDD	CFR-1	840,000	4,200	210,000	425,000	1,479,200
SED	CFR-1	450,000	22,500	112,500	225,000	810,000
Shared	CFR-1	155,000	7,600	38,700	63,000	264,300
Other	CFR-2	60,000	3,000	15,000	35,000	113,000
Total		$1,889,500	$56,500	$472,400	$1,004,000	$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, 0880 and 0890 are excluded from the operating costs.

Line No.	State Agency	Amount
Calculation of Operating Costs		
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
Calculation of Ratio Value Factor		
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
Allocation of Agency Administration Using Ratio Value		
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, 0920, 1230, 1690, 1910, 2860, 2980, 6910, 6920, 8810 and programs with an "A" program code index (startup) are deducted from CFR-3, line 44. Also, expenses for OPWDD programs coded 2091 and 5091 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 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.

Line No.	State Agency	Operating Costs
Calculation of Adjusted Operating Costs		
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
Calculation of Adjusted Ratio Value Factor (transfer to the item description col. Of line CFR-1, line 65)		
65	OASAS Allocation (line 53 divided by line 60)	.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.

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 two program/sites funded by OMH would be allocated agency administration expenses as follows (program type 1910 is an exempt program type):

CFR-1 Line #	Expense	OMH 2100 Program	OMH 1910 Program	Total OMH Programs
16	Personal Services	$230,500	$0	$230,500
17	Vacation Accruals	11,500	0	11,500
20	Fringe Benefits	57,700	0	57,700
41	OTPS	110,000	75,000	185,000
64	Total Operating costs	409,700	75,000	484,700
65	Agency Administration Allocation (line 64 times .171227)	$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 CFRs. Please refer to Appendix T for more information.

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 OMH and OPWDD must use units of service for allocating program 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 is allocated as follows:

Site A - $22,400 (annual salary) X (25/40) = $14,000
Site B - $22,400 (annual salary) X (15/40) = $ 8,400

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.

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. Square footage cost allocations must be calculated using the following procedure: (square footage should be the interior square footage).

1. Determine the number of square feet which is used exclusively by each program or State Agency, i.e., not shared in common.
2. Determine the number of square feet which is shared in common, i.e., lobby, restrooms, conference areas, etc.
3. Calculate an allocation ratio by dividing each exclusive square footage amount by the total site amount less the commonly shared amount.
4. Multiply each respective cost by the allocation ratios to determine the allocated dollar amount.

Example 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 - Utility Expenses = $5,000

Program A Allocation = $5,000 X .625 = $3,125
Program B Allocation = $5,000 X .375 = $1,875

One reason why the square footage method 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 X .61111= $3,056
Program B Allocation = $5,000 X .38889 = $1,944

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	Units of Service Only
Participant Wages	Units of Service Only
Staff Development	Full-Time-Equivalents
Supplies and Materials	Units of Service
Telephone	Number of Lines
Insurance-General	Ratio Value
Other	Units of Service

If the recommended allocation method does not apply, the provider should determine a more reasonable method of allocation. Example: A service provider needs to allocate supplies and materials costs to several program/sites. The recommended allocation method noted above is units of service. However, all the program/sites do not report units of service. In this case, a more reasonable method of allocating supplies and materials would be to allocate the cost based on usage.

Local Governmental Unit Administration (LGU) is considered a unique cost center over and above the cost to the agency as a service provider; therefore, a separate cost center should be maintained for LGU administration detailing personal services and other than personal services costs. LGU administration costs are required to be reported as a shared program (Program Code 0890) on the core CFR schedules (CFR-1 through CFR-6) and DMH-1. The journal entries should be made during the provider's normal accounting cycle. The following is a summary list of activities from Section 41.13 of the Mental Hygiene Law (MHL) which are associated with the responsibility of the LGU. Refer to the MHL for a complete description of each activity.

- Review services and local facilities for the mentally disabled of the area which it serves and their relationship to local need; determine needs of the mentally disabled of such area; and encourage programs of prevention, diagnosis, care, treatment, social and vocational rehabilitation, special education and training, consultation, and public education on mental disabilities.

- Develop a program of local services for the area which it serves, establish long-range goals of the local government in its programs for the mentally disabled, and develop intermediate range plans and forecasts, listing priorities and estimated costs.

- Direct and administer the development of a local comprehensive plan for all services for mentally disabled residents of the area, which shall be submitted to the department and used in part to formulate a statewide comprehensive plan for services.

- Seek to assure that under the goals and plans required, all population groups are adequately covered, sufficient services are available for all the mentally disabled within its purview, that there is coordination and cooperation among local providers of services, that the local program is integrated and coordinated with the programs of the department, and that there is continuity of care among all providers of services.

- Submit annually to the department for its approval and subsequent State Aid, a report of long-range goals and specific intermediate range plans as modified since the preceding report, along with a local services plan or unified services plan for the next fiscal year.

- Have the power, with the approval of local government, to enter into contracts for the provision of services and the construction of facilities including contracts executed pursuant to subdivision (e) of Section 41.19 of this article and the power, when necessary, to approve construction projects.

- Establish procedures for execution of local government, to enter into contracts for the provision of services and the construction of facilities including regulations to guide the provision of services by all organizations and individuals within its program.

- Make policy for and exercise general supervisory authority over or administer local services and facilities provided or supervised by it whether directly or through agreements, including responsibility for the proper performance of the services provided by other facilities of local government and by voluntary and private facilities which have been incorporated into its comprehensive program. Serve as a center for the promotion of community and public understanding of mental disabilities and of the services necessary for their care and treatment.

- Seek the cooperation and cooperate with other public health and social services agencies, public and private, in advancing the program of local or unified services.

- Further programs for special education and training, including career incentive and manpower and development.
- Have the power to conduct or contract for such research as may be useful for the discharge of its administrative duties and for the promotion of scientific knowledge of the mental disabilities.
- Have the powers necessary and proper for the effective performance of its functions and duties.
- Require the development of a written treatment plan as provided in rules and regulations of the commissioner.
- The local governmental unit for the county of Westchester shall establish a volunteer ombudsman pilot program within its territorial jurisdiction.
- The preceding list should enable a service provider to determine between agency administration functions (e.g., executive director) and LGU functions.
- A separate cost center should be set up for LGU administration on the LGU's general ledger. If this is not feasible, the following procedures must occur:

Personal Services

First, determine all personnel who spent 100% of their time on LGU administration.

For personnel who spent less than 100% of their time on LGU, a time study must be performed to properly allocate their time (refer to the guidelines for an acceptable time study in Appendix L).

Fringe Benefits

Applicable fringe benefits to employees who are working in LGU administration should be detailed as follows:

Example

i.	Fringe Benefits	$150,000
ii.	Total Personal Services	1,500,000
iii.	Fringe Benefit Percentage (line i/line ii)	.10
iv.	Joe Smith's Salary	50,000
v.	Fringe Benefits Applicable to Joe Smith (line iii x line iv)	5,000
vi.	Percentage of Time Related to LGU	10%
vii.	Personal Service Cost Related to LGU (line iv x line vi)	5,000
viii.	Fringe Benefits Applicable to LGU (line v x line vi)	500

Other Than Personal Services

First, determine if the cost related to LGU administration can be identified separately. The cost would include:

Professional Fees - Auditing and Accounting, Payroll Processing, Corporate Legal & Management Consulting, Investment Counseling, Public Relations and Advertising.

Employment Recruiting - Help Wanted Advertising, Employment Agency Fees, Costs of Temporary Office Help.

Supplies - General Supplies, Postage and Shipping Charges, EDP Software and Supplies, Cleaning and Maintenance Supplies.

Travel - Airfare, Train, Program Vehicle Operating Expenses (Insurance Registration, Fuel, Repairs), Conferences/Convention Costs for Program Staff.

Equipment - Depreciation, Interest, Lease Expenses for Fixed Major Moveable and Minor Equipment, Repair and Maintenance Expenses of Equipment.

Property - Repairs and Maintenance, Insurance, Taxes, Utilities, Rental/Lease, Depreciation Building Improvement, Leasehold Expenses and Improvements, Mortgage Interest (do not include principal amounts).

Other - Other expenses related to the administration of the program not reported above. These should be reported by item of expense.

Service providers may be requested to submit the County Wide Cost Allocation Plan. This plan is prepared and certified by an independent certified public accountant. This plan must include a listing of the type of service, amount and allocation base.

If LGU other than personal service costs are included with agency administration because the employee is only working a portion of their time on LGU administration, the following approach is required:

Determine the total amount of LGU personal service and fringe benefit costs; then divide that amount by the sum of your agency administration and LGU personal service and fringe benefits cost to determine the percent of LGU personal service and fringe benefits related to LGU administration. This percentage would be multiplied times other than personal service cost (e.g., OTPS, equipment and property cost) related to agency administration to determine total other than personal service cost related to LGU administration.

Example

1.	Total LGU personal service and fringe benefits	$120,000
2.	Total agency administration and LGU personal services and fringe benefits (includes LGU)	450,000
3.	Percentage of LGU personal service and fringe benefit cost to total agency administration and LGU (line 1/line 2)	.2667
4.	Total agency administration and LGU OTPS costs	525,000
5.	Portion of OTPS cost related to LGU administration (line 3 x line 4)	140,018
6.	Total agency administration and LGU equipment cost	25,000
7.	Portion of equipment cost related to LGU administration (line 3 x line 6)	6,668
8.	Total agency administration and LGU property cost	120,000
9.	Portion of property cost related to LGU administration (line 3 x line 8)	32,004
10.	**Total cost related to LGU Administration cost (lines 1, 5, 7 and 9)**	**$298,690**

Please refer to Volume XI, Section 6.04 (Special Payments – Municipal Overhead Costs) of the New York State Accounting System User Procedures for more clarification on the reimbursement of LGU administration costs. (A copy of Section 6.04 can be found on page 44.8.)

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 SPLITSAS 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

Counties		OASAS Percentage	OMH Percentage	OPWDD Percentage	Total 620/REG as % of Total
Clinton	Total	7.32	41.95	50.73	100.00
	620			100.00	9.90
	OT620	8.12	46.56	45.32	90.10
Columbia	Total	6.00	20.00	74.00	100.00
	620		0	100.00	37.00
	OT620	9.52	31.75	58.73	63.00
Cortland	Total	21.13	29.36	49.51	100.00
	620				0
	OT620				100.00
Delaware	Total	13.14	14.07	72.79	100.00
	620			*100.00	25.70
	OT620	17.68	18.94	63.38	74.30
Dutchess	Total	17.40	40.00	42.60	100.00
	620		0	100.00	18.75
	OT620	21.41	49.22	29.37	81.25
Erie	Total	30.55	51.64	17.81	100.00
	620			*100.00	8.66
	OT620	33.44	56.54	10.02	91.34
Essex	Total	20.44	20.82	58.74	100.00
	620				0
	OT620				100.00
Franklin	Total	9.55	11.50	78.95	100.00
	620				0
	OT620				100.00
Fulton	Total	34.06	57.40	8.54	100.00
	620				0
	OT620				100.00
Genesee	Total	19.19	33.82	46.99	100.00
	620				0
	OT620				100.00
Greene	Total	6.12	31.76	62.12	100.00
	620			100.00	1.83
	OT620	6.24	32.35	61.41	98.17
Hamilton	Total	34.68	38.16	27.16	100.00
	620				0
	OT620				100.00
Herkimer	Total	39.02	57.76	3.22	100.00
	620				0
	OT620				100.00
Jefferson	Total	22.70	72.21	5.09	100.00
	620				0
	OT620				100.00
Lewis	Total	9.33	27.06	63.61	100.00
	620				0
	OT620				100.00
Livingston	Total	100.00	0	0	100.00
	620	0	0	0	0
	OT620	100.00	0	0	100.00
Madison	Total	14.80	21.66	63.54	100.00
	620				0
	OT620				100.00

Counties		OASAS Percentage	OMH Percentage	OPWDD Percentage	Total 620/REG as % of Total
Monroe	Total	0	73.34	26.66	100.00
	620	0	0	100.00	2.58
	OT620	0	75.28	24.72	97.42
Montgomery	Total	41.61	58.39	0	100.00
	620				0
	OT620				100.00
Nassau	Total	0	92.90	7.10	100.00
	620				0
	OT620				100.00
Niagara	Total	22.12	56.09	21.79	100.00
	620				0
	OT620				100.00
Oneida	Total	23.82	25.91	50.27	100.00
	620				0
	OT620				100.00
Onondaga	Total	24.44	36.59	38.97	100.00
	620			100.00	11.46
	OT620	27.61	41.32	31.07	88.54
Ontario	Total	9.85	32.45	57.70	100.00
	620				0
	OT620				100.00
Orange	Total	14.99	46.41	38.60	100.00
	620			100.00	12.50
	OT620	16.87	52.21	30.92	87.50
Orleans	Total	13.95	14.02	72.03	100.00
	620				0
	OT620				100.00
Oswego	Total	4.05	44.10	51.85	100.00
	620				0
	OT620				100.00
Otsego	Total	12.72	16.01	71.27	100.00
	620				0
	OT620				100.00
Putnam	Total	16.37	57.71	25.92	100.00
	620				0
	OT620				100.00
Rensselaer	Total	10.25	55.23	34.52	100.00
	620				0
	OT620				100.00
Rockland	Total	13.56	56.62	29.82	100.00
	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

Counties		OASAS Percentage	OMH Percentage	OPWDD Percentage	Total 620/REG as % of Total
Schoharie	Total	18.92	15.89	65.19	100.00
	620				0
	OT620				100.00
Schuyler	Total	22.81	25.10	52.09	100.00
	620				0
	OT620				100.00
Seneca	Total	19.93	38.14	41.93	100.00
	620				0
	OT620				100.00
Steuben	Total	39.84	20.37	39.79	100.00
	620				0
	OT620				100.00
Suffolk	Total	**	68.71	31.29	100.00
	620			100.00	.72
	OT620		69.20	30.80	99.28
Sullivan	Total	20.03	32.60	47.37	100.00
	620			100.00	4.95
	OT620	21.07	34.30	44.63	95.05
Tioga	Total	9.21	42.34	48.45	100.00
	620				0
	OT620				100.00
Tompkins	Total	10.49	26.81	62.70	100.00
	620				0
	OT620				100.00
Ulster	Total	12.63	42.84	44.53	100.00
	620			100.00	20.80
	OT620	15.94	54.09	29.97	79.20
Warren	Total	7.50	52.90	39.60	100.00
	620				0
	OT620				100.00
Washington	Total	8.40	58.10	33.50	100.00
	620				0
	OT620				100.00
Wayne	Total	28.74	12.34	58.92	100.00
	620				0
	OT620				100.00
Westchester	Total	11.34	69.53	19.13	100.00
	620			100.00	1.94
	OT620	11.57	70.90	17.53	98.06
Wyoming	Total	36.53	63.47	0	100.00
	620				0
	OT620				100.00
Yates	Total	0	33.83	66.17	100.00
	620				0
	OT620				100.00

*** Methodology exception for Chapter 620, actual expenditures for Chapter 620.**
****Currently, separate OASAS administration may be changing back to Health Services.**

The following is from the New York State Office of the State Comptroller and can be found in Section 6.04 (Special Payments – Municipal Overhead Costs) of the New York State Accounting System User Procedures Manual.

The Federal Office of Management and Budget's Circular 74-4 (originally issued as Circular A-87, 1968) issued in December 1976, established standards for reimbursing state and local governments for overhead costs incurred in administering Federally funded programs. The principle set forth in the circular is that the Federal government should reimburse state and local governments for the total costs of administering Federal programs, except where restricted or prohibited by law,

In the case of local governments, the circular applies only to overhead cost reimbursements to the locality by the Federal government, It does not apply to State-financed programs and does not obligate the State to change any of its policies regarding reimbursements to localities for State-aided programs, For example, such local administrative costs as legal services, personnel, budgeting, accounting, chief executives office, etc, are not automatically eligible for State Aid,

Local administrative costs may be eligible for State Aid reimbursement subject to the following conditions which have been agreed to by OSC and the State Division of the Budget. The conditions are:

1. Payment for these costs cannot be made unless they were contemplated in the program costs set forth in the State's Executive Budget and approved by the State Legislature,

2. The extent to which the State may want to participate in a particular-program will depend upon the availability of funds in the light of other priorities. Therefore, the addition of central staff overhead may result in a decision to lower the percentage contribution by the State.

All personnel who work in more than one program should allocate their salary to the proper cost center during the normal accounting cycle based on actual time and attendance records. If this does not occur, the service provider must complete a time study for each employee who works in more than one program. Following are criteria for an acceptable time study. These criteria are the minimum standards. If necessary, a service provider can expand the length of the time study.

- A minimally acceptable time study must encompass at least two weeks per quarter of the cost reporting period.
- Each week selected must be a full week (Monday to Friday, Monday to Saturday, or Sunday to Saturday).
- The weeks selected must be equally distributed among the months of the cost reporting period, e.g., week 3 and 4 in March, week 2 and 3 in June, week 3 and 4 in September, and week 1 and 2 in December.
- No two consecutive quarters may use the same weeks for the study, e.g., week 1 and 2 in March and June.
- The time study must be contemporaneous with the costs to be allocated. Thus, a time study conducted in the current cost reporting year may not be used to allocate the costs of prior or subsequent cost reporting years.
- The time study must be provider specific.

This Appendix is not applicable for OMH, OPWDD and SED. OMH providers should refer to Part 587 and 588 of New York State Codes, Rules and Regulations.

The following rules have been established to reduce variation in service volumes due to inter-facility differences in organizational structure, operational interpretation of definitions, counting procedures and criteria for admitting family members. Relevant definitions follow this section.

The rules below apply to statistical reporting. Rules for billing Medicaid and most other third-party payors are more restrictive.

The following rules for counting visits apply to each program/site of the service provider.

Rule 1. A person (participant, client, collateral or significant other) can have no more than one full visit to a given program in a day (midnight to midnight).

Rule 2. A person can have a community residence day and, in addition, a visit to a non-residential program in the same day.

Rule 3. No combination of visits may add up to more than one full day visit. For example, a participant may have up to two half day visits to a program, but not a full day visit and another kind of visit.

Rule 4. When a participant attends a given program, then leaves and returns for a second attendance in the same day, the time of the two (or more) attendances must be cumulated and the visit reported as a single visit to that program.

Rule 5. If a client/participant and collateral or significant other are seen the same day, separate visits may be counted provided:

1. The collateral or significant other participates actively in the program and does not merely accompany or wait for the patient.
2. The collateral or significant other's participation is adequately documented in facility/unit records.

Rule 6. Only one visit to a program may be reported even when the participant receives more than one procedure or service or is served by more than one staff member or discipline during a visit.

Rule 7. Except for pre-admission screening, a participant and collateral or significant other visit may not be counted unless the patient is on the facility/unit rolls.

Rule 8. A visit is a face-to-face contact between a participant and a clinician whether singularly or in a group. For a group session, therefore, each individual should be counted as having a visit.

The following is a listing of the funding source codes to be used on Schedule DMH-3 by all DMH providers. OMH only index codes and OMH only Community Reinvestment codes are also listed.

Note: OASAS funded service providers should use the same funding source code and index combination(s) for each program or programs that are used on the fiscal period's budget of record. The budget of record for local contract funded programs is the State Aid Funding Authorization (Approval Letter). The budget of record for programs funded through a direct contract with OASAS is the Appendix B of the fully executed contract.

The five (5) funding source code indexes used by OASAS are:

Index	Definition	Fund Source
M	Mental Hygiene Program Fund	State
S	General Fund	State
F	SAPT Block Grant	Federal
P	Safe and Drug Free Schools and Communities	Federal
C	Various Categorical Grants	Federal

DMH Code #	OMH/ OASAS * Only Index	Description
001		**Local Assistance - Regular State/Federal** (OASAS, 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. **Unified Services Plan Financing** - (OASAS, 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 22, DMH-2, for unified services rates). **OMH service providers using funding source code 001 must also indicate the funding source index in the funding source code index field on DMH-3.**
001	A	**Adults** - (OMH Only)
004		**Chapter 620** - (OPWDD Only - 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 Only -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 Only) State Aid may be provided to local governments and to voluntary agencies in an amount up to 100% of the approved net operating cost for the delivery of jointly certified residential services to chemically dependent youth, certified community residential beds, certified alcoholism crisis services and innovative treatment and prevention programs pursuant to legislation and approved local services or unified services plans.

DMH Code #	OMH/ OASAS * Only Index	Description
014		**Community Support Services** - (OMH Only) 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. Approved costs are funded at the rate of 100% State participation. This funding code should only be used for approval letters between OMH and a county (see code #010 for direct contracts between OMH and voluntary agencies).
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 Only)
024		**SOICF Day Training** - (OPWDD Only) 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 - Article 41, Section 37, Title E, Mental Hygiene Law). Self-explanatory.
031		**Program Development Grants and Start-Up** - (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) for OMH or a new residential and day program for OPWDD. These costs must be incurred prior to the operation of the programs. These costs may include: - Reasonable legal and other professional fees; - Initial staffing; - Up to six months rent; - Furniture; - Reasonable rehabilitation costs. **OMH service providers using funding source code 031 must also indicate the funding source index in the funding source code index field on DMH-3.**
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** (OMH Only)
034	J	**Adult Case Management** (OMH Only)
034	K	**Children and Family Case Management** (OMH Only)
036		**Comprehensive Psychiatric Emergency Program** - (OMH Only). 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.

DMH Code #	OMH/ OASAS * Only Index	Description
037		**Ongoing Integrated Supported Employment Services** – (OMH Only) - These funds are intended for ongoing job maintenance services including job coaching, employer consultation, and other relevant supports needed to assist an individual in maintaining a job placement.
037	A	**Peer Support/Psych. Rehab.** – (OMH Only) – For 100% of net operating expenses incurred for approved new or expanded Peer Support and/or Rehabilitation programs.
037	P	**Personalized Recovery Oriented Services (PROS) -** (OMH Only)
038		**Mental Health Initiatives – OMH Member Item 100% 001 Funding**
039		**Demonstration Grants** – (OMH Only) - Local governments and service providers are granted State Aid of 100% of the net operating costs for approved demonstration projects. (Includes OMH general funds that are to be used for OMH adult program projects). **OMH service providers using funding source code 039 must also indicate the funding source index in the funding source code index field on DMH-3.**
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 Only - 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** - (OMH Only). For 100% of the net operating expenses incurred by local governments and voluntary providers in support of mental health programs for adults.
042		**Federal Medicaid Infrastructure Grant** – (OMH Only)
044		**Federal Community Mental Health Services Block Grant Funds** - (OMH Only). For 100% of the net operating expenses incurred by local governments and voluntary providers in support of mental health programs for children and families.
046		**Children and Families Program Grants** - (OMH Only). 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 Funds).
046	A	**Clinical Infrastructure – Children and Families** – (OMH Only)
046	C	**Coordinated Children's Services Initiatives** - (OMH Only)
046	G	**C & F Emergency Services** – (OMH Only)

DMH Code #	OMH/ OASAS * Only Index	Description
046	L	C & F Community Support Programs - (OMH Only)
046	M	**Mott Haven Community** - (OMH Only)
046	N	**Child & Family Clinic Plus (State Aid)** – (OMH Only)
046	P	**Child & Family Telepsychiatry (State Aid)** – (OMH Only)
046	S	**School Support Project Expansion** - (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)
058		**Family Support Services Funding** - (OPWDD Only). 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 Only) 100%.
062		**Federal HUD Shelter Plus Care –** (OMH Only) 100% - Includes care where funds do not flow through OMH; non-OMH funds only.
072	A	**Adult Community Residence Operating** - (OMH Only)
072	B	**Children CR Operating** - (OMH Only)
072	C	**Single Room Occupancy** - (OMH Only) - Singe Room Occupancy (SRO) NY/NY I.
072	D	**RCCA Operating** - (OMH Only)
072	E	**NY/NY 2 Operating** - (OMH Only)
072	F	**2000 Capital Bed Plan – Operating** – (OMH Only)
072	G	**New York/New York III Operating** – (OMH Only)
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** – (OMH Only)
073	G	**New York/New York III Property** – (OMH Only)
073	T	**Community Residence Property Costs for Former Transitional Care Individuals -** (OMH Only)
074		**Family Based Treatment** - (OMH Only). State Aid is provided to cover 100% of net cost.
076		**Residential Treatment Facilities** - (OMH Only) 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 Only) 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** – (OMH Only)
078	Z	**Single Room Occupancy (SRO)** (OMH Only) – Operating costs for Supported SRO related to 99/00 additions.

DMH Code #	OMH/ OASAS * Only Index	Description
080		**Home Care** - (OPWDD Only) Home care funds are provided through contractual arrangements with agencies, individuals and families to provide parent respite, home management, client training, and emergency assistance.
088		**Individual Support Services Transition Stipend** - (OPWDD Only) 100%
089		**Individual Support Services** - (OPWDD Only) 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)
091	T	**NYC DOT Stop-DWI (NYC Providers only)** – (OASAS Only)
096	A	**Community Based Family Care General** - (OMH Only) 100% State funded.
096	K	**Home and Community-Based Services Waiver** - General (OMH Only) 100% State funded.
111		**Federal Drug Free Schools & Communities Act -** (OMH C&F Community Support Program) - 100%
122		**Community Support Programs - Misc** (OMH Only). 100% State Funded**.**
122	L	**PROS Startup – Cash Advance -** (OMH Only) - 100% State Funded
122	P	**Prior Year Liability** (OMH Only) **–** Prior year liabilities reported in current year.
122	U	**PROS Start-Up Grants** (OMH Only)
122	W	**Western Care Coordination Project – Reallocated Savings** (OMH Only) – Off the top funding for the Western Care Coordination Project.
130		**Transitional Care -** (OMH Only - 100%)
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 Only) 100% State Aided
157		**Special Olympics** – (OPWDD Only) – 100% state funding to support the expenses associated with the statewide Special Olympics Games. Training Special Olympic athletes, organizing Special Olympic events/games, assisting local and state programs in public relations, education and outreach are the major activities.
162		**Geriatric Health Act** (OMH Only)
164		**Suicide Prevention** (OMH Only)
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%)

DMH Code #	OMH/ OASAS * Only Index	Description
184		**Health Care Adjustment VI – 2010** (OPWDD Only)
185		**Health Care Adjustment IV & V – 2008/2009** (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%)
540		**Co-Occurring Disorders** – (OMH Only)
541		**Managed Care Demonstration Programs** (OMH Only – 100%)

Depreciation

The CFR does not include schedules detailing depreciation expense on assets such as buildings, equipment and vehicles. However, the service provider is required to maintain depreciation schedules that include the following minimum information:

- Description of Asset
- Date of Acquisition
- Cost at Acquisition
- State/Federal Funding for Items
- Salvage Value
- Depreciation Method
- Useful Life Used for Depreciation Purposes
- Annual Depreciation Amount
- Accumulated Depreciation

The following general rules shall apply for the calculation and reporting of depreciation expense:

- Assets having a unit cost of $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. A provider may establish a capitalization policy with lower minimum criteria, but under no circumstances may the minimum limits be exceeded. Please note the new threshold of $5,000 is effective with periods beginning January 1, 2009 for calendar filers and July 1, 2009 for fiscal filers. Assets acquired prior to these dates should continue to be capitalized using the depreciation guidelines in effect at the time of purchase.

- Group purchases of like items should be treated as a single purchase. Group purchases of unlike items must be treated as if each item was purchased individually. Telephone systems and computer systems should be treated as a group purchase.

- For CFR purposes, the depreciable base is calculated by taking the total cost of the asset and subtracting the salvage value and the amount funded by State or Federal monies. (Note: Funds received via rates, prices, fees or net deficit funding should not be included in the calculation of State and Federal monies.) If 100% of the cost of an asset is funded specifically by State or Federal monies, the asset cannot be depreciated on the CFR. This will be a reconciling item between the CFR and the service provider's financial statements.

- Depreciation on assets which are shared among programs/sites or among program/sites and administration should be allocated on a reasonable basis. Documentation for the allocation basis must be available upon request. Refer to Appendices I and J.

- The "straight line method" of depreciation must be used for all classes of assets funded by the New York State Agencies. Use of the one month, six month, or full year convention is acceptable.

  When assets are shared by programs funded by more than one New York State Agency, the rules of majority funding shall dictate.

- The useful life of depreciable assets shall be the higher of the reported useful life or the useful life from the latest available edition of the Estimated Useful Lives of Depreciable Hospital Assets. This document is available from:

The publisher:	The American Hospital Association:
Health Forum, Inc.	The American Hospital Association
1 North Franklin	840 Lake Shore Drive
28th Floor	Chicago, IL 60611
Chicago, IL 60606	

The Estimated Useful Life Guidelines must be used in the calculation of depreciation expense unless the service provider can justify that an alternative useful life is more appropriate. Documentation to support the use of alternative useful lives must be available upon request.

Amortization

The CFR does not include schedules that calculate the amortization expense related to intangible assets, organizational expenses, leaseholds, leasehold improvements and mortgage expense. However, the service provider is required to maintain amortization schedules which include the following minimum information:

Description of Item
Beginning Date of Amortization
Length of Amortization
Costs to be Amortized
Accumulated Amortization
Current Year Amortization

The following general rules apply for the calculation and reporting of amortization expense:

- Organizational expenses are amortized over a period of 60 months, starting with the month the first participant is admitted to the program/site. Amortization of items which are shared among program/sites or among program/sites and administration should be allocated on a reasonable basis. Documentation for the allocation basis must be available upon request.

- Leasehold improvements are amortized over the term of the lease which includes any period for which the lease may be renewed, extended, or continued following either an option exercised by the service provider, or in the absence of an option, reasonable interpretation of past acts of the lessor and lessee pertaining to renewal, etc., unless the service provider establishes (omitting past acts) that it will probably not renew, extend, or continue the lease.

- Leasehold improvements which are the responsibility of the service provider under the terms of a lease are amortized over the useful life of the improvements or the remaining term of the lease, whichever is shorter.

- Mortgage expenses relate to the mortgages owed by the service provider and are amortized over the life of the mortgage. These expenses are **not allowed for OPWDD Residential Habilitation**.

Program Development Grants (PDGs)

Purpose

The purpose of Program Development Grant (PDG) funding is to assist residential service providers in commencing a new community residence program funded by OMH.

Approval and Distribution Process

PDG costs shall be reimbursed at 100% and may be advanced to the service provider according to their payment schedule. All PDG costs shall be documented by the provider as described in the submitted budget and shall be approved by the applicable field office. PDG's may run off-cycle.

Applicable Costs

Costs relating to starting a community residence program are appropriate PDG costs. Such costs include but are not limited to: initial recruitment, staffing, minor construction or remodeling costs, rent or other costs related to the use of space, purchases of automobiles or vans, furniture, some property costs, some architectural costs, or office equipment.

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 $5,000 in cost must be capitalized on the cost report, but can be expensed in the current year on the claim if approved in the budget).

Reporting on the CFR

PDG costs should be reported as a separate program column. No units of service are associated with PDG costs. For OMH PDGs, enter "A0" as the program code index (for example, 6070 would become 6070 A0 for a Treatment/Congregate program receiving PDG funds).

START-UPS - OMH

Purpose

The purpose of OMH Start-ups is to assist ongoing OMH service providers in purchasing equipment as a one time, non-recurring expense which, if included in the cost of the program, would exaggerate unit costs.

Approval and Distribution Process

OMH Start-up costs shall be reimbursed at 100% and may be advanced to the service provider according to their payment schedule. All OMH Start-up costs shall be documented by the service provider as described in the submitted budget and shall be approved by the applicable field office. OMH Start-ups may run off-cycle.

Applicable Costs

One time purchases or non-recurring costs are appropriate for OMH Start-ups. Such costs may include but are not limited to: major repairs due to emergency situations, purchases of vehicles, office equipment, consultant costs, which would have the effect of artificially increasing unit costs in 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 $5,000 in cost must be capitalized on the cost report, but can be expensed in the current year on the claim if approved in the budget).

Reporting on the CFR

OMH Start-up costs should be reported by using "A0" as the program code index after the four digit program code (for example, 6050 would become 6050 A0 for a Supported Housing program receiving Start-up funds).

START-UPS - 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.

These guidelines are to be utilized by all OMH providers who operate Community Residences, Family Based Treatment Programs or other residential programs which have exempt income. Exempt income is income generated that exceeds the fixed amount defined in the fiscal model. (Refer to the residential exempt income policy and guidelines for specifics). The procedures for reporting these amounts on the Consolidated Fiscal Report are as follows:

Exempt Income (all sources except Medicaid):

For budget and claiming purposes, all income received (income from sources other than Medicaid) is to be reported as appropriate on the CFR. As noted in the CR Contract Policy and Guidelines, exempt income has been defined as being that amount by which actual income received exceeds the amount of the fiscal model income and is to be excluded from application against budgeted gross expenses in determining net deficit (and is retained by the service provider). For budget and claiming purposes, "exempt" income should be reported as "non-GAAP Adjustments to Revenue" on line 39 of Schedule DMH-2.2.

For budget and claiming purposes, exempt income which is spent in the current contract period will be reported on the appropriate revenue lines of Schedule DMH-2.1 and expenditures from exempt income will be reported in the appropriate expense category (lines 5 through 10 of Schedule DMH-2.1). If exempt income is partially spent in the current contract reporting period, that which is unspent must be reported on line 39 of Schedule DMH-2.2.

For CFR reporting on the core schedules (CFR-1 to CFR-6), exempt income should be considered a revenue, reported on the accrual basis of accounting and be reported on line 10 of Schedule CFR-2 and lines 69, 70, 71 or 74 of Schedule CFR-1.

Medicaid Exempt Income

For budget and claiming purposes, all Medicaid income is to be reported on the CFR, on line 17 of Schedule DMH-2.1. As noted in the CR Contract Policy and Guidelines, exempt income has been defined as being that amount by which actual income received exceeds the amount of the Fiscal Model with 50 percent of all Medicaid income in excess of the Fiscal Model expectation, to be applied against budgeted Gross Budget Expenses; and 50 percent of that amount to be excluded from application against budgeted Gross Budget Expenses in determining net deficit (and is retained by the service provider). To differentiate "exempt" income on the CFR, "exempt" income should be reported as "non-GAAP Adjustments to Revenue" on line 39 of Schedule DMH-2.2.

For budget and claiming purposes, exempt income which is spent in the current contract period will be reported on line 17 of Schedule DMH-2.1; and expenditures from exempt income will be reported in the appropriate expense category (lines 5 through 10 of Schedule DMH-2.1).

For CFR reporting on the core CFR schedules (CFR-1 to CFR-6), Medicaid Exempt Income must be considered a revenue, and be reported on the accrual basis of accounting on line 72 of Schedule CFR-1 and on line 10 of Schedule CFR-2.

Note: For budget and claiming purposes, exempt income not spent which is reported on line 39 of Schedule DMH-2.2 must be detailed by revenue source (SSI, Medicaid or other).

Select the position title and code that reflects functions performed by the individual(s) and enter the appropriate title and code number on Schedule CFR-4 and, if applicable, Schedule CFR-4A.

Note: Certain position titles are unique to individual New York State agencies. Be certain that the title used is acceptable for the New York State Agency that provides your funding. OMH service providers should note that certain position title codes are only acceptable for certain types of OMH programs.

- **Agency administration staff must be assigned position title codes from 600 through 699.**
- **Local Governmental Unit (LGU Program Code 0890) staff must be assigned position title codes from 700 through 799.**
- **Program administration staff must be assigned position title codes from 500 through 599.**
- **Program/site staff must be assigned position title codes from 100 through 499.**

Below is an alphabetic listing of position titles to assist you in choosing appropriate titles. Following the alphabetic list is a numeric list of position title codes and definitions.

Position Title	Position Title Code
Accountant (Agency Administration)	606
Accountant (Program Administration)	506
Accountant/Bookkeeper (LGU Administration)	703
Administrative Assistant	612
Assistant Executive Director	602
Assistant Mental Hygiene Director	702
Assistant Principal (SED Only)	515
Assistant Program or Assistant Site Director	502
Behavioral Support Staff (SED Only) – replaces Crisis Intervention Worker	243
Case Manager (Does not apply to SED)	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	267
Counselor - Rehabilitation (Does not apply to SED)	305
Counselor (OMH CR Only)	203
Crisis Prevention Specialist (OMH RTF Only)	354
CSE/CPSE Chairperson (SED Only)	511
Curriculum Coordinator (SED Only)	237
Developmental Disabilities Specialist/Habilitation Specialist- QMRP - Clinical (OPWDD Only)	309
Developmental Disabilities Specialist - QMRP - Direct Care (OPWDD Only)	207
Dietician/Nutritionist (OMH, OPWDD & OASAS Only)	336
Director of Division	604
Emergency Medical Technician (Does not apply to SED)	312
Executive Director/Chief Executive Officer	601
Food Service Worker (OASAS & OPWDD use 336 for Dietician/Nutritionist)	101
Guidance Counselor (SED Only)	236
Housekeeping and Maintenance	102

Position Title	Position Title Code
Identification/Information Referral (OASAS Only)	346
IEP Coordinator (SED Only)	238
Intake/Screening (Does not apply to SED)	343
Intensive Case Manager (OMH Only)	313
Intensive Case Manager/Coordinator (OMH Only)	314
Job Coach/Employment Specialist (OMH and OPWDD Only) (SED - See Codes 255 and 257)	254
Manager (OMH CR Only)	204
Marketing (Agency Administration)	614
Marketing (Program Administration) (Does not apply to SED)	509
Marriage and Family Counselor/Therapist (Does not apply to SED)	344
MD on call for OMH RTF Restraint Reviews (OMH Only)	353
Mental Hygiene Director/Commissioner of Mental Hygiene	701
Mental Hygiene Worker (not for OMH CR) (Does not apply to SED)	201
Nurse - Licensed Practical	316
Nurse Practitioner/Nursing Supervisor	315
Nurse - Registered	317
Nurses Aide/Medical Aide	339
Office Worker (Agency Administration)	605
Office Worker (LGU Administration)	704
Office Worker (Program Administration)	505
Other Agency Administration Staff	690
Other Clinical Staff/Assistants	390
Other Direct Care Staff	290
Other LGU Administration Staff	790
Other Program Administration Staff	590
Other Support Staff	190
Paraprofessional - Non-Disabled (SED Only)	265
Paraprofessional - Social Services (SED Only)	213
Peer Specialist (OMH Only)	266
Pharmacist (Does not apply to SED)	350
Physician's Assistant (SED – Allowed Only in 9190 Evaluation Program)	319
Physician - M.D. (SED - Allowed Only in 9190 Evaluation Program)	320
Prevention/Education (OASAS Only)	345
Principal of School (SED Only)	514
Production Staff (Does not apply to SED)	400
Program or Site Director	501
Program Research/Evaluation (Does not apply to SED)	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
Residential Treatment Facility (RTF) Transition Coordinator (OMH Only)	352
Security	105
Senior Counselor (OMH CR Only)	205
Service Coordinator Medicaid Service Coordination (OPWDD Only)	351
Social Worker, Licensed (LMSW, LCSW)	324
Social Worker Master's Level (MSW)	325
Staff Training (Agency Administration)	620
Staff Training (Program Administration) (OASAS and OMH Only)	520

Position Title	Position Title Code
Staff Training (Program/site) (OPWDD and SED only)	347
Student (OMH Only)	355
Supervising Teacher (SED Only)	215 and 518
Supervisor (OMH CR Only)	206
Supervisor - Social Services (SED Only)	513
Teacher Aide	228
Teacher Assistant	232
Teacher Aide/Assistant - Substitute	230
Teacher - Art	269
Teacher - Blind and/or Deaf (SED Only)	263
Teacher - Coverage/Floating (SED Only)	227
Teacher - Foreign	272
Teacher - Music	270
Teacher - Non-Disabled (SED Only)	260
Teacher - Other	222
Teacher - Physical Education	220
Teacher - Reading	274
Teacher - Resource Room	273
Teacher - Special Education	218
Teacher - Speech Certified (SED Only)	225
Teacher - Substitute (SED Only)	224
Teacher - Technology	271
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
Transition Coordinator (SED Only)	255
Transition Specialist (SED Only)	257
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)	DEFINITION
		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.
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.

CODE NUMBER	POSITION TITLE/ JOB TITLE(S)	DEFINITION
205	Senior Counselor (OMH CR Only)	All individuals who perform this role as defined in the OMH Community Residence Program Mode.
206	Supervisor (OMH CR Only)	All individuals who perform this role as defined in the OMH Community Residence Program Model.
207	Developmental Disabilities Specialist QMRP - Direct Care (OPWDD Only)	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 developmentally disabled persons 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. Certified Special Education teacher serving as supervisor of teachers less than 25 percent of assignment pursuant to Part 80 of the Regulations of the Commissioner of Education. If supervising more than 25 percent of assignment, see Code 518.
218	Teacher - Special Education	A certified teacher who provides specialized instruction to students with disabilities.
220	Teacher - Physical Education	Self-explanatory.
222	Teacher - Other	A teacher performing functions not otherwise coded. Job titles may include teachers of: Drama, Home Economics, Industrial Arts, Keyboarding. See codes 263, 269, 270, 271, 272, 273 and 274 for other specialized teachers.
224	Teacher - Substitute (SED Only)	Self-explanatory. This is not a permanent position but is maintained on payroll records.
225	Teacher - Speech Certified (SED Only)	Certified as Teacher of Speech and Hearing Handicapped or Teacher of Deaf and Hearing Impaired.
227	Teacher - Coverage/Floating (SED Only)	An individual who covers sick days on a regular basis as a permanent position or as an extra teacher. The position is maintained on payroll records.
228	Teacher Aide	Assists teachers in non-teaching duties such as managing records, materials and equipment, attending to the physical needs of students and supervising students.
230	Teacher Aide/Assistant - Substitute	An individual who covers sick days of teacher aide or teacher assistant personnel. This is not a permanent position but it is maintained on payroll records.
232	Teacher Assistant	An individual who, under the supervision of a certified teacher, assists in such duties 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.

CODE NUMBER	POSITION TITLE/ JOB TITLE(S)	DEFINITION
237	Curriculum Coordinator (SED Only)	A certified administrator or certified Special Education teacher with five years teaching experience who is knowledgeable about the New York State Learning Standards and responsible for ensuring that the program's curriculum is developed and aligned to such Standards. Monitors implementation of the curriculum, oversees curriculum training, and any curriculum adaptations.
238	IEP Coordinator (SED Only)	A certified or licensed individual in one of the job titles below who is responsible for ensuring that IEP recommendations are implemented and that each service provider responsible for implementation of a student's IEP is aware of his or her IEP responsibilities, including specific accommodations, program modifications, supports and/or services for the student, prior to implementation of such program. Serves as a liaison to the school district Committee on Special Education. Job Titles: Certified Special Education Teacher, School or Licensed Psychologist, Social Worker (Licensed or Master's Level), or Certified Administrator.
243	Behavioral Support Staff (SED Only) Replaces Crisis Intervention Worker	An individual with less than a Master's degree who assists in the implementation of positive behavioral interventions, supports and services.
254	Job Coach/Employment Specialist (OMH & OPWDD Only) (SED- See Codes 255 and 257)	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.
255	Transition Coordinator (SED Only)	Conducts Level 1 Vocational Assessment, participates in development of transition plans, coordinates school and local resources to provide vocational opportunities, develops post-secondary linkages, and works with VESID's Vocational Rehabilitation Offices to coordinate vocational assessments beyond Level 1.
257	Transition Specialist (SED Only)	Conducts and monitors implementation of transition services on a student's IEP, such as training, education, employment, and where appropriate, independent living skills. May include direct assistance to persons in supported employment placements or other job experiences and to their employer, under the direction of a special education teacher, social worker or psychologist.
260	Teacher - Non-Disabled (SED Only)	Self-explanatory. (For use in Preschool Integrated Programs).
263	Teacher - Blind and/or Deaf (SED Only)	Teacher who provides special education services to students with disabilities who are blind and/or deaf. Job titles include teachers certified as Teacher of the Blind and Partially Sighted, Teacher of the Visually Impaired, Teacher of the Deaf, Teacher of the Hard of Hearing, or Teacher of the Deaf/Blind.
265	Paraprofessional - Non-Disabled (SED Only)	Self-explanatory. (For use in Preschool Integrated Programs). Includes Non-Disabled Teacher Aides and Assistants.

CODE NUMBER	POSITION TITLE/ JOB TITLE(S)	DEFINITION
266	Peer Specialist (OMH Only)	Peer Specialists work with residents to facilitate the individual's recovery process.
267	Counselor - Alcoholism and Substance Abuse (CASAC)	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.
269	Teacher - Art	Teacher who is certified to provide art education to meet Part 100 program and units of credit requirements.
270	Teacher - Music	Teacher who is certified to provide music education to meet Part 100 program and units of credit requirements.
271	Teacher - Technology	Teacher who is certified by SED to provide technology studies to meet Part 100 program and units of credit requirements.
272	Teacher - Foreign	Teacher who is certified by SED to provide foreign language to meet Part 100 program and units of credit requirements.
273	Teacher - Resource Room	Certified special education teacher that provides resource room services consistent with a student's Individual Education Program (IEP).
274	Teacher - Reading	Teacher who is certified in reading by SED to provide reading instruction.
290	Other Direct Care Staff	Anyone not listed in the 200 series engaged in providing direct care services.
	CLINICAL STAFF	
301	Case Manager (Does not apply to SED)	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 (Does not apply to SED)	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 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 developmentally disabled persons engaged in providing or supervising services to program participants and their families.
312	Emergency Medical Technician (Does not apply to SED)	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.

CODE NUMBER	POSITION TITLE/ JOB TITLE(S)	DEFINITION
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.
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. Use of this title for SED is limited to consulting psychiatric services and not for the direct provision of psychiatric services.
319	Physician's Assistant (SED - Allowed in 9190 Program Only)	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. (SED – Allowed in 9190 Program Only)	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 working in accordance with the exemptions found in Article 153, Title 8 of the Education Law.
323	Psychology Worker/Other Behavioral Worker	Individuals with less than a Master's degree in psychology working in accordance with the exemptions found in Article 153, Title 8 of the Education Law who assist in the implementation of positive behavioral interventions, supports and services.

CODE NUMBER	POSITION TITLE/ JOB TITLE(S)	DEFINITION
324	Social Worker - Licensed (LMSW, LCSW)	Individuals, who are licensed in this discipline by SED. LCSW must meet the additional educational experience and examination requirements as mandated.
325	Social Worker - Master's Level (MSW)	Individuals with a Master's degree in social work who are not licensed by SED 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, dance, etc.) and hold at least a Bachelor's degree and, where applicable, are certified by SED or a recognized national professional organization.
333	Therapist - Occupational	Individuals licensed in this discipline by SED.
334	Therapist - Physical	Individuals licensed in this discipline by SED.
335	Therapist - Speech	Individuals licensed in this discipline by SED.
336	Dietician/Nutritionist (Does not apply to SED)	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 (Does not apply to SED)	An individual who is responsible for initial assessment, screening and referral of persons presented for admission
344	Marriage and Family Counselor/Therapist (Does not apply to SED)	An individual responsible for providing assessment or counseling services to more than one member of the family in the same session or where applicable, licensed as a marriage and family therapist.
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 (Program/Site) (OPWDD & 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 (Program/Site) (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.

CODE NUMBER	POSITION TITLE/ JOB TITLE(S)	DEFINITION
350	Pharmacist (Does not apply to SED)	Licensed by SED and responsible for dispensing medications.
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.
353	MD on call for OMH RTF Restraint Reviews (OMH Only)	OMH Residential Treatment Facilities are required to provide 24 hour coverage of a physician to review the need for Restraint of a child. This code should only be used after the normal working hours of the RTF's physician(s), and should only be used on schedule CFR-4A.
354	Crisis Prevention Specialist (OMH RTF Only)	This individual will be responsible for the coordination of all aspects of training, mentoring and ongoing monitoring of crisis prevention activities. The Crisis Prevention Specialist, in close collaboration with the RTF Director, will be charged with achieving a significant reduction in the number/duration of physical holds with the ultimate goal of the elimination of the use of restraint.
355	Student (OMH Only)	Student who is participating in a program approved by the NYS Education Department that leads to a degree or license in one of the professional disciplines. Students must be supervised and evaluated in accordance with a signed agreement between a provider and a NYS Education Department approved educational program, and pursuant to a provider's policies and procedures for student placements and clinical supervision.
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 (Does not apply to SED)	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.

CODE NUMBER	POSITION TITLE/ JOB TITLE (S)	DEFINITION
	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 (Program Administration)	Responsible for record-keeping, billing, correspondence and general office duties. Job titles may include Bookkeeper, Clerk, Receptionist, Secretary and Typist.
506	Accountant (Program Administration)	Responsible for the establishment and maintenance of the program's systematic fiscal transactions for the agency. This position title does not include consultants.
509	Marketing (Program Administration) (Does not apply to SED)	An individual responsible for promoting the program's services for the primary purpose of increasing facility utilization.
510	Program Research/Evaluation (Does not apply to SED)	Responsible for conducting ongoing evaluation or research.
511	CSE/CPSE Chairperson (SED Only)	A certified or licensed individual in one of the job titles below who serves as the chairperson of the Committee on Special Education (CSE) or Committee on Preschool Special Education (CPSE). Individuals must be qualified to provide or supervise special education and be knowledgeable about the general education curriculum and the availability of special education resources. Job Titles: Certified Special Education Provider (e.g., teacher or related service provider), Certified School Psychologist, Licensed Psychologist, Certified Administrator.
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/Education Department Head (SED Only)	Self-explanatory. Job titles may include: Program Specialist, Director of Program Development, Program Coordinator/Manager.
518	Supervising Teacher (SED Only)	Provides for direct supervision of teachers. Certified administrator or supervisor of special education programs if serving more than 25 percent of his or her assignment in such capacity pursuant to Part 80 of the Regulations of the Commissioner of Education.
520	Staff Training (Program Administration)	An individual responsible for the training of program staff. (**OPWDD and SED**: Use Code 347).

CODE NUMBER	POSITION TITLE/ JOB TITLE (S)	DEFINITION
521	Utilization Review/Quality Assurance (Program Administration)	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.
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 (Agency Administration)	Responsible for agency-wide record-keeping, billing, correspondence and general office duties. Job titles may include Bookkeeper, Clerk, Receptionist, Secretary and Typist.
606	Accountant (Agency Administration)	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 (Agency Administration)	An individual responsible for promoting the agency's services.
620	Staff Training (Agency Administration)	An individual responsible for training of agency staff.
621	Utilization Review/Quality Assurance (Agency Administration)	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.

CODE NUMBER	POSITION TITLE/ JOB TITLE (S)	DEFINITION
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
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 (LGU Administration)	The individual responsible for recording and maintaining mental hygiene fiscal transactions of the county.
704	Office Worker (LGU Administration)	The individual performing as secretary/clerk and/or billing mental hygiene programs of the county.
790	Other LGU Administration Staff	Any LGU administration staff that are not listed in the 700 series.

Administering Agency	Code	CFDA
FEDERAL:		
Employment and Training Administration	ETA	17.219, 17.232, 17.238, 17.243
Employment and Training Administration	ETAWIN	13.646
Health and Human Services	HHS	
Community Mental Health Services (CMHS) Block Grant		93.958
Individuals with Disabilities and Education Act (IDEA)		84.027
Juvenile Accountability Incentive Block Grant		16.523
Projects for Assistance in Transition from Homelessness (PATH)		93.150
Medicaid		93.775
Medicaid Salary Sharing		93.778
Stewart B. McKinney Homeless Permanent Housing Program (PHP)		14.235
Stewart B. McKinney Homeless Shelter Plus Care (S+C)		14.238
Office of Human Development Services	OHDSDD	13.630
Office of Human Development Services	OHDS	13.644
Department of Justice	DOJ	16.452, 16.541, 16.560, 16.561, 16.601, 16.602
National Institute on Mental Health	NIMH	13.242, 13.244, 13.281, 13.282, 13.295
National Institute on Alcohol Abuse and Alcoholism	NIAAA	13.252, 13.271, 13.272, 13.273, 13.274, 13.891, 13.898, 131.899
National Institute on Drug Abuse	NIDA	13.275, 13.277, 13.278
National Highway Traffic Safety Administration	NHTSA	20.600
Office of Education	OE	13.427
Office of Education	OE1	13.446, 13.449
Office of Education	OE2	13.451, 13.489, 13.560
Office of Education	OE3	13.416, 13.482, 13.499
All Other Federal Education Programs	OE4	
U.S. Veteran's Administration	VA	
Old Age Survivors Disability Insurance	OASDI	
Federal Emergency Management Agency	FEMA	
All Other Federal Grants	OTHFED	
STATE:		
Office of Alcoholism and Substance Abuse Services (for Substance Abuse Services)	OASAS - SAS	

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.

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

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:

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.

   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.

6. 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.

7. 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.

8. CFR-6 is completed reporting all Governing Board and Compensation information.

   Please see Section 19 for detailed instructions on completing schedule CFR-6.

9. 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.

10. 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.

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.

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 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.

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

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 Total Operating Costs	10,000 200,000	=	.050000 Ratio Value Factor

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

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

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-CAS	OMH	OPWDD	Total
Allegany	49,927	$2,290	$ 6,057	$16,653	$25,000
Cattaraugus	83,955	343	7,962	16,695	25,000
Cayuga	81,962	0	5,600	19,400	25,000
Chautauqua	139,750	0	25,000	0	25,000
Chemung	91,070	3,750	6,500	14,750	25,000
Chenango	51,401	3,000	12,000	10,000	25,000
Clinton	79,894	1,600	11,900	11,500	25,000
Columbia	63,094	0	12,500	12,500	25,000
Cortland	48,599	2,300	9,400	13,300	25,000
Delaware	48,055	1,900	4,400	18,700	25,000
Essex	38,851	10,000	10,000	5,000	25,000
Franklin	51,134	0	25,000	0	25,000
Fulton	55,073	4,000	18,000	3,000	25,000
Genesee	60,370	3,000	16,000	6,000	25,000
Greene	48,195	0	11,000	14,000	25,000
Hamilton	5,379	6,902	14,025	4,073	25,000
Herkimer	64,427	3,300	20,500	1,200	25,000
Jefferson	111,738	5,000	18,000	2,000	25,000
Lewis	26,944	0	12,500	12,500	25,000
Livingston	64,328	0	25,000	0	25,000
Madison	69,441	5,000	10,000	10,000	25,000
Montgomery	49,708	3,000	22,000	0	25,000
Ontario	100,224	1,300	11,600	12,100	25,000
Orleans	44,171	5,000	15,000	5,000	25,000
Oswego	122,377	5,000	15,000	5,000	25,000
Otsego	61,676	5,000	10,000	10,000	25,000
Putnam	95,745	3,896	14,400	6,704	25,000
Schenectady	146,555	12,500	12,500	0	25,000
Schoharie	31,582	4,729	3,973	16,298	25,000
Schuyler	19,224	2,000	11,500	11,500	25,000
Seneca	33,342	1,500	4,750	18,750	25,000
St. Lawrence	111,931	12,500	12,500	0	25,000
Steuben	98,726	6,645	6,968	11,387	25,000
Sullivan	73,966	1,900	4,900	18,200	25,000
Tioga	51,784	3,000	12,700	9,300	25,000
Tompkins	96,501	8,333	8,334	8,333	25,000
Ulster	177,749	2,300	14,800	7,900	25,000
Wayne	93,765	1,284	8,948	14,768	25,000
Wyoming	43,424	14,300	10,700	0	25,000
Yates	24,621	0	8,800	16,200	25,000
TOTAL		$146,572	$490,717	$362,711	$1,000,000

These guidelines are to be utilized by all counties who receive Federal Medicaid Administrative Salary Sharing (Salary Sharing) revenue from OMH. Through participation in the Salary Sharing program, counties can be reimbursed for part of the local governmental cost of (a) county staff time associated with the administration of the mental health portion of the Medicaid program and/or (b) subcontractors who administer the mental health portion of the Medicaid program. The local governmental costs associated with the administration of the mental health portion of the Medicaid program are hereafter referred to as **Local Medicaid Administration**.

Note: Counties are liable for all Salary Sharing claims subject to Federal and state audit, and are solely responsible for ensuring that their Salary Sharing claims for Local Medicaid Administration are in compliance with applicable Federal Regulations. Regarding Salary Sharing in general, please refer to Title 42 (Public Health) of the Code of Federal Regulations (CFR), Part 433 (State Fiscal Administration); regarding subcontracts specifically, please refer to Title 42, CFR Part 434.6 (General Requirements for All Contracts and Subcontracts). All documentation of contract specifications must be kept by the County.

Purposes Toward Which Local Medicaid Administration Salary Sharing Revenue Can Be Applied

Local Medicaid Administration Salary Sharing revenue is to be used for county/NYCDMH operated mental health services only, and must be applied toward either:

- mental health LGU Administration costs (OMH program 0890 – LGU Administration); or
- any other exclusively-OMH-funded, county/NYCDMH operated mental health program costs (i.e., programs that receive funding through OMH funding sources such as Local Assistance and CSS, and this includes non-Medicaidable programs).

Procedure To Be Followed If Local Medicaid Administration Salary Sharing Revenue Is To Be Utilized For LGU Program Expansion

If, during the course of the year, the Local Medicaid Administration Salary Sharing revenue received from OMH is used specifically for OMH LGU administration program expansion (OMH program 0890), then the expenditures related to LGU program expansion must be assigned entirely to OMH, and therefore, the total amount of LGU administration expenses split among the participating disabilities is to be reduced by an amount equal to the expenditures related to OMH LGU Administration program expansion. After the LGU Administration expenses have been reduced, calculate the shares assigned to each disability based on the "Department of Mental Health County Administration Percentage Splits for the Year 1988". The LGU Administration share assigned to OMH (based on the "splits") is then to be increased by the expenditures made for OMH LGU administration program expansion.

Other Reporting Provisions

If a line utilized for the purpose of reporting Salary Sharing revenue contains revenues other than Salary Sharing revenue, then a subschedule that details all of the sources of revenue reported on this line needs to be attached to the CCR.

Procedures Specifically Regarding the Approved CFR Software

Providers who: (1) utilize approved CFR software for the purpose of completing year-end claiming schedules, and; (2) report all or some portion of the Salary Sharing revenue received from OMH in the LGU Administration program (under OMH program 0890) must ensure that the Salary Sharing revenue is <u>not</u> divided among the participating disabilities based on the "Department of Mental Health County Administration Percentage Splits for the Year 1988", but is applied entirely as an offset to the share assigned to OMH (you will need to directly enter this revenue information at the data entry screens for the schedules detailed above.)

As a reminder, Chapter 166 of the Laws of 1991 added Article XI-B to the State Finance Law which promoted prompt contracting with not-for-profit (NFP) organizations and mandated by law prompt contract timeframes. If the NFP does not receive its first contract payment on time (i.e., in strict accordance with the contract payment schedule), the Department of Mental Hygiene will incur an interest penalty that will be payable from the State Operations appropriation. Since an annual report must be provided to the Governor's Office of Management and Productivity and the State Legislature regarding compliance with the timeframes for processing contracts and interest liabilities incurred, it is especially important that all NFP's receive their first contract payment on time.

A recent amendment to the Prompt Contract Law (PCL) adds some limited flexibility to the original provisions set forth in Article XI-B of the State Finance Law, and provides for a smoother flow of program services and payments. The revisions should enable State agencies to process contracts and payments for NFP's in a timely manner without incurring unreasonable interest liabilities. The revisions provide more reasonable timeframes for processing local grant awards (i.e., Legislative Member Items) and federally funded contracts; allow State agencies and NFP's to agree to waive interest payments in certain circumstances; eliminate interest penalties for contracts executed and funded in whole or in part for services rendered in a prior fiscal year; and limit the amount of time any one agency may suspend the law's timeframe to 4 ½ months in any State fiscal year.

The Division of the Budget has issued Budget Bulletin B-1131 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 volition, 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, including 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 and the chairman of the legislative fiscal committees. The notification must specify the length of the suspension.

   Example: A statewide Deficit Reduction Plan ("DRP") is issued, and because of the chaos usually associated with it, a "time out" from the prompt contract timeframes for processing contracts is called by the State Agency. A written notice suspending the timeframes would be issued to the NFP. If such a notification is not issued, the State Agency could be interest liable.

3. **Federally Funded Programs** - The new provision delays interest liabilities for federally funded contracts until four months after the State Agency receives its federal funds, or after the contract's first payment due date, whichever is later.

Example: OMH could delay processing its CMHS Block Grant funded contracts until it has received its Notice of Block Grant Award from the federal government, and then take up to four months to process the contracts. However, OMH has been processing contracts to OSC and having them pre-approved ("executory"). This ensures that the contracts are processed within the prompt contract timeframes.

4. **Timeframes for Local Grant Award** - The timeframes for processing Member Item contracts begins on the date DOB informs the State Agency with lists identifying the recipients of such contracts. The State Agency then has four months from the DOB identification to process the contract to OSC, and as required by the current law, the AG and OSC have one month to complete the approval process, for a total timeframe of five months from identification. Without this new provision, 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 17-w[3]).

This appendix lists certain items of expense that are considered non-allowable. Where this manual and/or state codes, rules and regulations are silent, DMH will defer to the guidelines published in the Provider Reimbursement Manual, commonly referred to as PRM-15. SED providers should refer to the SED Reimbursable Cost Manual for specific items that are not allowable for SED programs. 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, such cost must not exceed the lower of actual cost to the related organization or the price of comparable services, facilities or supplies that could be purchased elsewhere.

9. Costs of providing services and/or treatment to individuals who have not met the required eligibility criteria for the program/site.

10. Cost for contributions made to contingency reserve funds where such funds did not have prior approval by the appropriate DMH office. Contingencies do not include pension funds, self-insurance funds or funded depreciation accounts mandated by DMH offices.

11. Costs related to the purchase of alcoholic beverages.

12. Compensation to members of a Community Mental Health, Mental Retardation and Alcoholism Services Board, in excess of expenses incurred in the performance of official duties.

13. Costs for mental health clinics or other services operated exclusively in conjunction with schools (applicable to Aid to Localities funding only).

14. Costs associated with local governmental legislative bodies or executive staff not associated with the provision of DMH services.

15. Costs of books, subscriptions or periodicals which are not addressed to the provider agency.

16. Costs associated with the conferring of gifts or providing cash payment to an individual when the primary intent is to confer distinction on, or to symbolize respect, esteem or admiration for the recipient. If such gifts or honoraria constitute acknowledgement for services rendered, such as a speaker's fee, such costs are allowable.

17. Real estate taxes (except if part of a lease agreement or if part of purchase agreement), excise taxes on telephone services and other use taxes where organizations are eligible for exemptions from such taxes.

18. Costs incurred prior to the approved beginning date of a new program/site or expansion of a program/site unless such costs are specifically approved in writing by the required DMH office.

19. Costs incurred by a service provider that does not have an approved operating certificate or provider agreement where required, to render the particular services.

20. Costs associated with operating New York State Department of Motor Vehicle Drinking Driver programs including a prorated share of administration costs. (OASAS Only).

21. Fees for psychiatric examinations under the Criminal Procedures Law or Family Court Act including fees paid to State employees if the examination is conducted during normal working hours (except for reasonable transportation expenses); fees paid to State employees if not accompanied by documentation from the County Fiscal Officer that there is a shortage of examiners in the county; fees above $200 for one (1) person including both an examination and court appearance.

22. For programs funded through Aid to Localities, costs representing capital additions or improvements are unallowable as operating expenses (Title 14 NYCRR) unless specifically authorized in a legislative appropriation.

23. Unless specified judicially, the cost of services provided to an agency or a program participant of an agency in legal actions against the State.

24. For programs receiving funding through Aid to Localities, the costs associated with debt service, whether principal or interest are unallowable (Title 14 NYCRR). These operating costs may include that part of rental costs paid to those community health or mental retardation service companies that represent interest paid on obligations incurred by such companies organized pursuant to Article 75 and who participated in mortgage financing in accordance with Chapter 1304 of the Laws of 1969.

25. Costs associated with depreciation of assets purchased in whole or in part with State and/or Federal funds are unallowable. The provider's share of such depreciation is allowable based upon the proportional share of the asset purchased by provider funds. Do not make adjustments for assets purchased from fees, rates or net deficit funding. **Note: If asset purchases with a value of $5,000 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 including but not limited to Supplemental Executive Retirement Plans, any Nonqualified Deferred Compensation Plan subject to IRC Subsection §457(f) or any retirement plan not qualified by the Employee Retirement Income Security Act of 1974 (ERISA).

30. Expenses that are prohibited by Federal, State or local laws.

31. Expenses included as a cost of any other program in a prior, current or subsequent fiscal period.

32. Costs of investment counsel and staff and similar expenses incurred solely to enhance income from investments.

Hospitals receiving funds from DMH via direct and/or indirect contracts are generally required to complete an abbreviated CFR which records with reasonable accuracy, discrete DMH costs. Refer to Section 2.0 for specific reporting requirements.

The Institutional Cost Report (ICR) and the Medicaid Stepdown are not required to be submitted to DMH by the hospitals.

The following procedures are to be used exclusively by hospitals in filling out Schedule DMH-2.

The CFR is to be completed by hospitals using this manual as a guide.

In calculating expected administrative and overhead expenses, use the most recent available allocation percentages from the stepdown derived from the last Institutional Cost Report (ICR) submitted to the Office of Health Systems Management. Follow this procedure unless there is reason to believe that there will be a change in the percentage that will be allocated to Mental Hygiene programs.

If ICR stepdown percentages are not used, please so indicate and explain the methodology used to calculate the percentages.

The logical integrity between the schedules in the CFR must be maintained as prescribed throughout the manual.

Hospitals who received State Aid based on a line item expense reimbursement methodology will continue to receive State Aid in this manner (based upon the procedures outlined above).

Hospitals who previously received State Aid based on approved Medicaid rates rather than on a line item expense reimbursement methodology will continue to receive State Aid based upon their approved Medicaid rates.

When the DMH allocates deficit funding to a service provider, it is expected that these limited resources will be maximized on behalf of mental hygiene recipients. Specifically, this means that surpluses for approved mental hygiene programs should be utilized to offset deficits in other approved mental hygiene programs, thus allowing for optimal use of DMH State dollars.

With an effort to continue to maximize State Aid dollars and to establish a consistent in-contract/out-of-contract policy, the following policy for OMH funded agencies was implemented July 1, 1994 for the New York City region and January 1, 1995 for all upstate regions:

OMH Policy Statement: In-Contract/Out-of-Contract Reporting

The following medicaidable, ambulatory mental health programs must be reported as in-contract, even if net deficit funding is not supporting the program: Personalized Recovery Oriented Services (PROS), Clinic Treatment; Continuing Day Treatment; Partial Hospitalization; Intensive Psychiatric Rehabilitation Treatment (IPRT); Intensive Case Management/Supportive Case Management. 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, Project Liberty and Sheltered Workshop Programs. Inpatient programs will continue to be eligible for out-of-contract status at the discretion of the OMH Community Budget and Fiscal Liaison Units and therefore profits from these programs would not be used to reduce deficits in the above-listed programs.

Although Community Residence, Family-Based Treatment, Project Liberty and Sheltered Workshop Programs are considered to be in-contract programs, by virtue of receiving State Aid net deficit funding, exempt income generated by one of these programs is not required to be used to offset in-contract deficits.

Also, even though Personalized Recovery Oriented Services (PROS), Intensive Case Management, Supportive Case Management, Blended Case Management and Assertive Community Treatment programs are reported as in-contract, please refer to the appropriate spending plan guidelines (http://www.omh.state.ny.us/omhweb/spguidelines/) and the Case Management Program Guidelines for the rules regarding profits for these programs.

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, Family-Based Treatment and Sheltered Workshops. Application of these profits will be made during the desk audit of the CCR.

The following guidance is designed for use by independent public accountants who have been engaged to do one of the following:

(1) To perform an audit of general purpose financial statements and to express an opinion on selected information included in the Schedules that comprise the Consolidated Fiscal Report as identified on Schedule CFR-ii, when the CFR and the financial statements cover the same time period.

(2) To perform an examination in accordance with SSAE 10 as amended by SSAE 14 and to express an opinion on selected information included in the Schedules that comprise the Consolidated Fiscal Report as identified on Schedule CFR-iiA, when the CFR and the financial statements cover different time periods.

The following guidance has been developed by the CFR Interagency Committee with the assistance of a task force of the New York State Society of Certified Public Accountants (NYSSCPA). The objective of the guidance is to provide uniformity in the scope of work completed by independent accountants on the CFR Schedules.

Framework for Conducting the Audit/Examination and Expressing an Opinion on Selected Information in the Schedules

a) Gain an understanding of the methods used by the entity to allocate expenses not only to programs, but also to multiple sites within programs where applicable. Failure to properly allocate expense to programs and to sites within programs could have a direct effect on the entity's financial statements, and if material, affect the independent accountant's report on those financial statements. Therefore, if the independent accountant does not consider the allocation procedures to be appropriate, he or she shall request that they be revised, or consider modifying the accountant's opinion.

Notes: Any changes to the wording of the CFR-ii/iiA Independent Accountant's Report must be pre-approved by the funding NYS agencies.

The CFR instructions require the use of the "ratio-value" method for allocating agency administrative expenses and for allocating program administrative expenses in those situations where time records or other documentation are not available to support another basis. Refer to Appendix I of the CFR Manual for a complete explanation of allocating administrative expenses.

The CFR instructions also recommend the use of Appendix J for allocating various shared program/site expenses.

b) Although the procedures specified in this guidance are required, it is expected that any departures from them shall be justified by the particular circumstances encountered during the course of the audit/examination. The detailed procedures for testing the CFR schedules as set forth in the following section are the minimum procedures to be performed. Judgment is required, however, to determine the extent of testing necessary in order for the independent accountant to express an opinion.

c) A comprehensive payroll test. Because of the significance of payroll expenses, it is expected that the audit/examination procedures would include a comprehensive test of payroll payments. Under such an approach, a sample of payroll payments would be tested not only for existence, authorization, time worked, and accuracy of rates and summarization, but also for distribution to the appropriate program

or non-program expense. In other words, if the employee being tested performs services in the program area, the test should show that the distribution to the program and site, where applicable, has been made in compliance with the applicable authorizing requirements of the granting documents or regulations related thereto.

d) Tests of expenses other than payroll. Typically, such tests include a combination of analytical procedures and tests of details. For detail expense transactions selected for testing, it is expected that the items would be tested to determine if they represent goods and services actually received during the period by the organization. Also, if the transactions were for program services, they shall be tested to determine that they were charged to the appropriate program and site in compliance with all applicable laws, regulations, policies, procedures and guidelines.

A suggested general approach to the work on the schedules is as follows:

For an audit, the details reported by program in the CFR are reconciled to the program amounts in the financial statements. For an audit/examination of programs that operate at multiple sites, work done for site level expenses and revenues, should generally be analytical in nature. Having reviewed the agency's site-allocation procedures and verified that the procedures were followed, and having made tests of payroll and other than payroll expenses as described earlier, the work should consist primarily of a review of the allocated amounts for reasonableness and consistency.

Framework for Conducting the Audit of Financial Statements and Expressing an Opinion on Selected Information in the Schedules

The minimum audit procedures in the guidelines are based upon the following assumptions:

(1) The reporting period for the general purpose financial statements and the CFR are the same.

(2) The financial statements have been prepared in accordance with Generally Accepted Accounting Principles.

Framework for Conducting the Examination and Expressing an Opinion on Selected Information in the Schedules

In some cases, the time period for the CFR Schedules differs from the time period of the financial statements. It is not uncommon for some not-for-profit agencies to have a fiscal year end of June 30, whereas the period for the CFR might be for the calendar year. The reverse could also be true, depending on the location of the provider.

It is permissible for agencies to submit their CFR report with the financial statements as of one date and the CFR Schedules as of a later date. An exception is an organization that received SED funding and no DMH funding. In that case the organization's fiscal year must end June 30 and the CFR would be prepared for the corresponding year ended June 30. The following section outlines the procedures that the independent public accountant might perform in order to issue such a report.

(1) Perform transaction and control tests for the stub period (period after the financial statements included in the CFR Schedules) that would normally be performed throughout the whole year for next year's

financial statement audit. It is important that the extent of testing (i.e., the scope of work) in the stub period be proportionately the same as for the year covered by the financial statements.

(2) On a test basis, trace the client's trial balance or schedules that support the amounts reported in the CFR to the general ledger and supporting worksheets and schedules.

(3) Perform analytical procedures on the amounts reported in the CFR.

(4) Determine by inquiry and observation that appropriate cut-offs and accruals/reversals have been applied to the CFR.

(5) Inquire about changes in accounting procedures during the stub period and their possible effect on stub period amounts.

(6) Inquire about changes in allocation methods and procedures.

(7) Perform the procedures as applicable on each schedule as set forth in the accompanying Minimum Audit/Examination Procedures.

Minimum Audit/Examination Procedures

The following procedures are the minimum procedures that need to be performed. The independent public accountant shall consider the extent of testing and such other procedures necessary to render an opinion on the schedules as set forth in the accompanying "Independent Accountant's Report."

General Procedures

(1) Obtain and become familiar with the CFR manual that contains the instructions for the specific cost report period being audited/examined. The independent public accountant shall have a working knowledge of the manual including all updates, particularly those detailed in the CFR Manual Transmittal letter for the period. The manuals and transmittal letters are available at: http://www.oms.nysed.gov/rsu/Manuals_Forms/Manuals/CFR.html.

(2) Obtain an understanding of the service provider’s internal control structure and their process for completing the CFR.

(3) Review and evaluate the service provider's basis for concluding that the program/sites shown on the CFR are either funded or certified by OMH, OPWDD, OASAS, and/or SED.

(4) Review the submission requirements contained in the CFR Manual. Review the agency's conclusion as to which CFR submission type (either Full, Abbreviated, Article 28 Abbreviated or Mini-Abbreviated) the agency is required to file and whether a CPA opinion is required.

(5) Based on steps 2 and 3 above, conclude that all applicable schedules have been prepared.

(6) Verify that NYS CFRS software has been used to produce the CFR.

(7) Verify that a Document Control Number (DCN) has been assigned to the CFR submission under review and that the DCN on Schedule CFR-ii/CFR-iiA matches the DCN on all of the other CFR schedules and worksheets contained in the CFR submission under review.

CFR-1--Program/Site Data-Section A: General Information - Procedures

On a test basis:

(1) Consider whether the provider has used the proper program type and codes included in Appendices E through H. If not, seek correction. Review changes from the prior year for appropriateness. Compare programs on CFR to licenses, contracts, approval letters and operating certificates.

Note: For entities operating one or more OASAS certified/funded programs, all programs both funded and unfunded must be reported.

(2) Trace the Units of Service (line 13) reported by site to supporting work papers or documentation and monthly statistical information. Verify that the process uses the appropriate Unit of Service measures for the program type being reported. Analytic procedures should be used to compare year to year values on a test basis.

Note: For OASAS certified/funded programs:

(1) Request that the provider run a query from the OASAS Client Data System (CDS) through the Monthly Service Delivery function (MSD) identifying by program site the units of service provided during the fiscal reporting period under review.

(2) Compare and verify that the units of service reported by site on the CFR match the units of service reported by the entity to the OASAS Client Data System (CDS) through the Monthly Service Delivery function (MSD).

CFR-1--Program/Site Data-Section B: Expense - Procedures

(1) CFR-1, line 17. Test related records and ensure that the proper vacation accruals have been posted to this line by program/site. The entry on this line shall be the difference between the accrual posted at the end of the last cost report period and the current cost report period. An entry only needs to be posted if a vacation accrual adjustment is made at year-end.

(2) CFR-1, lines 20, 41, 48, 63 and 64. For an audit, agree or reconcile subtotals for each program to amounts in the financial statements. For an examination, agree or reconcile subtotals for each program to amounts in the client prepared supporting documentation. Compare the amounts per site to similar amounts for prior years. Test amounts by site to client prepared allocation documentation.

On a test basis:

(3) Trace items of expense not transferred from other audited/examined Schedules to trial balances or client prepared allocation documentation to determine that amounts are reasonable.

(4) Verify that OTPS, equipment and property expenses have been allocated to programs and sites using an acceptable allocation method as described in Appendix J.

(5) Verify whether the adjustments on line 66 are complete, accurate and in compliance with the policies, procedures and guidelines defined and described for schedule CFR-5 (Transactions with Related Organizations/Individuals) and Appendix X (Adjustments To Reported Costs).

CFR-1--Program/Site Data – Section C: Revenue - Procedures

On a test basis:

(1) Trace revenue by category and program/site to the supporting documentation.

(2) Verify that programs funded by Medicaid reported Medicaid revenue under Section C, and those programs not funded by Medicaid do not report Medicaid revenue under Section C.

(3) Verify the reasonableness of adjustments to revenue, especially Uncollectible Accounts Receivable on line 97 and Exempt Contract Income on line 101.

CFR-2--Agency Fiscal Summary - Procedures

(1) On a test basis, trace Column 7 Other Program Totals to the agency's general ledger, financial statements (if applicable) and/or other supporting documentation and determine whether they are properly classified.

(2) For an audit, agree or reconcile amounts on this Schedule with the agency's certified financial statements. If the agency total revenues and expenses differ from the CFR-2 amounts, verify that the provider has prepared the Reconciliation in the CFRS software. Confirm that the entries are appropriate.

(3) For an examination, agree or reconcile amounts on this Schedule with the client prepared supporting documentation.

CFR-3--Agency Administration - Procedures

(1) Trace on a test basis amounts on lines 2, 3-4, 6-17, 19-24, 26-36, 38 and 39 to general ledger accounts, trial balances, or client prepared supporting documentation.

(2) Verify that the costs reported on this schedule are appropriately classified as Agency Administrative Costs.

(3) Verify whether amount on line 38 is for parent agency administration. Trace amounts to general ledger accounts, trial balances, or client prepared supporting documentation on a test basis and verify that the allocation method used to determine the parent agency administration charge is appropriate and reasonable.

(4) Verify whether the adjustments on line 41 are complete and accurate and in compliance with the policies, procedures and guidelines defined and described for schedule CFR-5 (Transactions with Related Organizations/Individuals) and Appendix X (Adjustments To Reported Costs).

CFR-4-Personal Services - Procedures

(1) On a test basis, verify that the appropriate position title code from Appendix R has been used.

(2) Inquire about and review the procedures used to determine that contracted positions are not included on this schedule.

(3) Inquire about the standard workweek and ensure that it is consistent with that used on the CFR-4.

(4) Inquire if employees are working in multiple program/sites and/or multiple job functions and/or program administration and/or agency administration. If yes, review the allocation methodology(ies) used to ensure they are consistent with the allocation requirements in the CFR Manual [These procedures would have been performed in connection with the comprehensive payroll test described in the introductory section.]

(5) On a test basis trace the number of days/hours worked and hourly rates, as reported in the payroll records, with the number recorded on the time sheets and in the approved pay schedules. For any employee in the test group who was hired or terminated during the year confirm that payroll changes and pay rates are in accordance with the agency's policies and procedures. [These procedures would have been performed in connection with the comprehensive payroll test described in the introductory section.]

(6) Use analytic procedures to test for variances which may indicate inaccurate reporting of salaries per FTE.

CFR-4A-Contracted Direct Care and Clinical Personal Services - Procedures

(1) Inquire about the method used in identifying contractual arrangements. Review schedule and relate to other audit/examination work for possible omissions.

(2) On a test basis, determine that the appropriate position title code from Appendix R has been used.

CFR-5 - Transactions with Related Organizations/Individuals - Procedures

(1) Review the procedures for identifying related organizations/individuals. Obtain a list of related organizations/individuals and any transactions between the CFR reporting entity and related organizations/individuals. Based upon a reading of minutes, contracts, and other documentation, consider whether the list of related parties and transactions is complete.

(2) Review the schedule of transactions with related organizations/individuals for completeness and accuracy of the disclosures.

(3) On a test basis, check that transaction costs that are greater than the actual cost to the related organization or individual are properly adjusted in accordance with the policies, procedures and guidelines defined and described in the CFR Manual, and transferred to CFR-1, line 66 or CFR-3, line 41.

(4) Obtain representation from management that to the best of its knowledge and belief all transactions with related organizations/individuals have been listed on the schedule CFR-5.

(5) On a test basis, review the methods used to allocate costs of lease/rental agreements with related organizations/individuals to program/sites on CFR-5, Section C.

CFR-6 Governing Board and Compensation Summary - Procedures

(1) Verify the accuracy of the annualized salaries under Section 3, Column 5.

(2) Obtain representation from Management that Section 3 is complete.

OMH-1—Units of Service by Program/Site - Procedures

(1) Obtain an understanding of the provider's process for capturing Unit of Service information.

(2) Review Unit of Service/Hours of Service information and trace on a test basis the amounts to client prepared supporting documentation.

(3) On a test basis, use analytic procedures to relate revenue reported to units of service.

OMH-4- Units of Service by Payor – Procedures

(1) Obtain an understanding of the provider's process for capturing unit of service information by payor type.

(2) On a test basis, trace units of service to client prepared supporting documentation.

(3) Obtain an understanding of the provider's process for collecting bad debts.

(4) On a test basis, verify the reasonableness of amounts reported for non-paid services (Lines 11 – 14).

OPWDD-3--HUD Revenues and Expenses - Procedures

Trace HUD revenues and expenses to trial balance or client prepared supporting documentation.

OPWDD-4—Fringe Benefit Expense and Program Administration Expense Detail - Procedures

On a test basis:

(1) Trace the amounts on lines 1 through 9 to the general ledger accounts, trial balances, or client prepared supporting documentation.

(2) Trace the amounts on lines 11 through 25, to the general ledger accounts, trial balances or client prepared supporting documentation.

SED-1-Program and Enrollment Data - Procedures

On a test basis:

(1) Review the reasonableness of the reported FTE's in comparison to reported SED revenues and certified tuition rates.

(2) Trace FTE's by program on lines 100 and 107 to the client prepared supporting documentation.

(3) Determine that the school has calculated FTE's in accordance with the instructions contained in the CFR manual Section 33.0.

(4) Agree the classroom ratios reported on lines 201, 301, 401 and/or 501 to those reported on the SED program approval letter.

SED-4-Related Service Capacity, Need and Productivity

(1) Verify staffing and contracted service hours reported in columns 2a and 2b agree to the reported program staffing on CFR-4 and CFR4a, respectively.

(2) Trace RS-2 data to the appropriate lines on SED-4.

RESERVED FOR FUTURE USE

Local Governmental Units (LGUs) and municipalities that are required to submit a certified Consolidated Fiscal Report (CFR) may use the Compliance Review in lieu of the accountant's certification which appears on Schedule CFR-ii/CFR-iiA. The Compliance Review is intended to ensure that a CFR has been subjected to certain agreed upon procedures specified by the Department of Mental Hygiene (DMH). The Compliance Review must include the Document Control Number (DCN) of the CFR submission that was reviewed.

The certification must address the following for agreed upon procedures:

- Verification that there is a system in place and maintained for recording data in accordance with CFR definitions.

- Verification that source documents are available to support the reported data and are maintained for DMH review and audit for a minimum of 7 years following DMH's receipt of the CFR. The data must be fully documented and securely stored.

- Verification that there is a system of internal controls to assure the accuracy of the data collection process and recording system and that reported documents are not altered. Test that documents are reviewed and signed by a supervisor as required.

- Verification that the data collection methods are adequate to support the amounts reported.

- Verification that all amounts reported can be traced to supporting documentation.

- Documentation of an analytical review of the reported data to provide evidence that the CFR is reasonable and consistent with prior reporting periods, as well as other facts known about LGU/municipality operations.

DMH has specified and agreed to a set of procedures for the independent auditor to perform to satisfy the requirements of CFR Certification. Procedures a through i, as listed below, should be performed on Schedules: CFR-1, lines 13, 16,17, 20, 41, 48, 63, 64 through 67, 69 through 107; CFR-2; CFR-3; CFR-4; CFR-4A; CFR-5; DMH-1; 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.

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:

Community Mental Health Board
(name of LGU/municipality)

We understand that the (name of LGU/municipality) receives Medicaid reimbursement and/or Aid to Localities for programs funded by the New York State Department of Mental Hygiene (DMH) and in connection therewith, the LGU/municipality is required to report certain information to DMH.

DMH has established the following standards with regard to the data reported to it in the Consolidated Fiscal Report (CFR):

- A system is in place and maintained for recording data in accordance with CFR definitions.

- Source documents are available to support the reported data and maintained for DMH review and audit for a minimum of seven years following DMH's receipt of the CFR. The data are fully documented and securely stored.

- A system of internal controls is in place to assure the accuracy of the data collection process and that the recording system and reported documents are not altered. Documents are reviewed and signed by a supervisor, as required.

- The data collection methods are adequate to support the amounts reported.

- Reported amounts agree to supporting documentation.

- Reported amounts are consistent with prior reporting periods and other facts known about LGU/municipality operations.

We have applied procedures to the data contained in the accompanying CFR with Document Control Number _____, for the fiscal year-ending (date). Such procedures, which were agreed to and specified by DMH, were applied to assist you in evaluating whether the LGU/municipality complied with the standards described in the second paragraph of this report. Additional procedures performed, which are agreed to by the LGU/municipality but not by DMH, are described in a separate attachment to this report. This report is intended solely for your information and DMH, and should not be used by those who did not participate in determining the procedures.

The following information and findings came to our attention as a result of performing the procedures described in the attachments to this report.

Itemize all information and findings. If none, so state.

The agreed upon procedures are substantially less in scope than an examination, the objective of which is an expression of an opinion on the CFR. Accordingly, we do not express such an opinion. Also we do not express an opinion on the LGU's/municipality's system of internal control taken as a whole.

In performing the procedures, except for the information and findings described above, no matters came to our attention which caused us to believe that the information included in the CFR for the fiscal year-ending (date) is not presented in conformity with the requirements established by DMH. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report relates only to the information described above, and does not extend to the LGU's/municipality's financial statement taken as a whole.

The following guidelines are to be used for the purpose of budgeting and claiming Medicaid Revenue from: (a) Level I Comprehensive Outpatient Program (Level I COPS), (b) Community Support Program (CSP), and (c) Level II COPS fee supplement.

General Instructions

(a) For Article 31 and D&TC providers, Level I COPS, CSP, and Level II COPS revenue should be reported on the CBR and CCR on the cash basis of accounting consistent with Section 3.0 of the CBR manual (the Methods of Accounting Section). This reporting requirement was implemented for the purpose of preventing discrepancies between the reserve amounts (overpayments) calculated by providers, and the revenue reconciliations calculated by the OMH.

(b) For Article 28 providers, 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-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).

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 consistent 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 Level I COPS reserve. Clinic services rendered on or after July 1, 2008 will no longer be subject to the 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.

(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 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 COPS/CSP Rate Setting Unit. When Level II COPS overpayments occur, they will be recovered by the State through the Level II 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 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 no 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.

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 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 Example:		Enter your Amounts 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:			
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
Line 29 - Other Revenue:			
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:			
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

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.

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. Vehicles considered lavish or extravagant when compared to the prudent buyer concept are not eligible for reimbursement.

Gifts

The cost of gifts is not eligible for reimbursement. Awards given for employee recognition purposes are not considered gifts.

Office Furnishings

The cost of office furnishings and decorations considered lavish or extravagant when compared to the prudent buyer concept, is not eligible for reimbursement. Fine art and collectibles are not reimbursable.

Tuition

Cost for the training and educational enhancement of staff members are eligible for reimbursement where it can be demonstrated that such training and educational enhancement afforded the employee promotional opportunities within the agency and/or enhanced the quality of service delivery to consumers.

Housing

Costs associated with the provision of housing to agency personnel are eligible for reimbursement when the agency requires that such personnel reside on the grounds, or in close proximity to the facilities operated by the agency.