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SUBJECT **SECTION**

APPENDICES

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 14 NYCRR 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 its 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 its 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 14 NYCRR Part 588.

Competitive Employment (OMH Vocational Programs Only): Work in the competitive labor market that is performed on a full-time or part-time basis in an integrated setting and for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals who are not disabled.

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 14 NYCRR 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.

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: 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 Medicaid programs funded through OMH and/or OPWDD. (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.

Fundraising: Activities undertaken to induce potential donors to contribute money, securities, services, materials, facilities, other assets, or time. These activities include the following: direct mail, telephone solicitation, door-to-door canvassing, telethons, special events and others.

Note: Please refer to page 8.13 FAQs for reporting requirements for fundraising and special events.

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.

Integrated Employment (OMH Vocational Programs Only): A work situation where each employed individual with a disability has equal opportunity to interact with co-workers without disabilities. Individuals who are paid to provide services to support the work of individuals with disabilities are not included when evaluating integration.

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.

Medicaid Managed Care: A delivery system of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.

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.

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.

Metropolitan Commuter Transportation Mobility Tax (MCTMT): 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. 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.

Safety Net Payments: The Centers for Medicare and Medicaid Services (CMS) denied the continuation of the waiver for the Clinic Uncompensated Care distribution. The revised model, now known as Safety Net Payments, maintains the eligibility criteria utilized under the Clinic Uncompensated Care Program. Safety Net Payments replaced Uncompensated Care effective July 28, 2016.

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.

Signature (Signed): Signatures shall be handwritten or an electronic signature. An electronic signature is defined as an electronic sound, symbol, or process, attached to or logically associated with an electronic record and executed or adopted by a person with the intent to sign the record. An attestation must also be completed prior to use of an electronic signature. This attestation will be provided during the upload stage of the CFR certification pages.

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.

State Paid Services: 100% State funding of services for people with disabilities who do not qualify for Medicaid but are approved for state funding of the service (formerly known as Mirrored Services). Not to be confused with Net Deficit Funding.

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.

Safety Net Payments replaced Uncompensated Care effective July 28, 2016.

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
ACCES	Adult Career and Continuing Education Service
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	Consolidated 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
DDRO	Developmental Disabilities Regional 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
ECE	Division of Early Care and Education
FBTP	Family-Based Treatment Program
FTE	Full-Time Equivalent
GAAP	U.S. 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
MMIS	Medicaid Management Information Systems
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 Addiction Services and Supports
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
U.S. GAAP	U.S. Generally Accepted Accounting Principles

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 Chief Executive Officer.
5. Schedule CFR-ii/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. Schedule CFR-iv was not signed and dated by the Chief Executive Officer.
11. Schedule CFR-2A was not completed.
12. Areas of non-compliance addressed on desk reviews of prior period CFRs were not addressed by the service provider on their current CFR submission.
13. The program codes, program code indexes and/or site codes were incorrect.
14. When reporting periods coincide, total expenses and revenues reported on the service provider's audited and 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.
15. All required schedules were not completed for all funding CFR State Agencies.
16. Required financial statements were not submitted.
17. The CFR submitted was not prepared using approved CFRS Web.
18. The CFR was not transmitted electronically via the Internet.
19. The Document Control Number (DCN) of the Internet CFR submission did not match the DCN that appeared on certification Schedules CFR-i, CFR-ii/CFR-iiA, CFR-iii and CFR-iv.
20. The wrong type of CFR submission was submitted (for example, an Abbreviated CFR was submitted instead of a Full CFR)
21. 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 website.

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 example 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
COMMUNITY ORIENTATED RECOVERY AND EMPOWERMENT SERVICES (CORE)		
CORE Empowerment Services – Peer Supports	CORE	4650
CORE Family Support and Training (FST)	CORE	4690
CORE Psychosocial Rehabilitation (PSR)	CORE	4710
CORE Community Psychiatric Support and Treatment (CPST)	CORE	4720
ADULT BEHAVIORAL HEALTH HCBS		
Ongoing Supported Employment (OSE)	Adult BH HCBS	4610
Intensive Supported Employment (ISE)	Adult BH HCBS	4620
Transitional Employment	Adult BH HCBS	4630
Pre-Vocational Services	Adult BH HCBS	4640
Education Support Services (ESS)	Adult BH HCBS	4660
Intensive Crisis Respite (ICR)	Adult BH HCBS	4670
Short-Term Crisis Respite	Adult BH HCBS	4680
Habilitation	Adult BH HCBS	4700
CHILDREN'S BEHAVIORAL HEALTH HCBS		
Waiver Individualized Care Coordination	Children's BH HCBS	2230
Waiver Family Support	Children's BH HCBS	2250
Waiver Crisis Response	Children's BH HCBS	2260
Waiver Skill Building	Children's BH HCBS	2270
Waiver Intensive In-Home	Children's BH HCBS	2280
Waiver Youth Peer Advocate	Children's BH HCBS	2370
CRISIS		
Medically Supervised Withdrawal Services – Inpatient	Crisis	3039
Medically Supervised Withdrawal Services – Outpatient	Crisis	3059
Medically Managed Withdrawal and Stabilization Services	Crisis	3500
Medically Monitored Withdrawal and Stabilization Services	Crisis	3510
INPATIENT		
Substance Use Disorder Inpatient Rehabilitation Services	Inpatient	3550
OPIOID TREATMENT		
Residential Opioid Treatment	OPIOID	2030
Outpatient Opioid Treatment	OPIOID	2050
KEEP Units Outpatient	OPIOID	2150
Residential Opioid Treatment to Abstinence	OPIOID	6030

OUTPATIENT		
Problem Gambling Treatment	Outpatient	2780
Medically Supervised Outpatient	Outpatient	3520
Enhanced Medically Supervised Outpatient	Outpatient	3528
Outpatient Rehabilitation Services	Outpatient	3530
Specialized Services Substance Abuse Programs	Outpatient	4045
Family Peer Support Services (FPSS)	Outpatient	4900
Mobile Crisis Intervention (CI)	Outpatient	4910
Children & Family Treatment & Support Services: Youth Peer Support (YPS)	Outpatient	4920
Psychosocial Rehabilitation (PSR)	Outpatient	4930
Other Licensed Practitioner (OLP)	Outpatient	4940
Community Psychiatric Support and Treatment (CPST)	Outpatient	4950
PREVENTION		
Problem Gambling Prevention	Prevention	2790
Prevention Resource Centers	Prevention	3100
Primary Prevention Service	Prevention	5520
Other Prevention Services	Prevention	5550
PROGRAM SUPPORT		
Problem Gambling Resource Center	Program Support	2710
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		
Continuum of Care Rental Assistance 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
Permanent Supported Housing - High Frequency Medicaid Consumers	Recovery	3480
Youth Clubhouse	Recovery	3920
Recovery Community Centers	Recovery	3970
Recovery Community Organizing Initiative	Recovery	3980
RESIDENTIAL		
Residential Rehabilitation Services for Youth (RRSY)	Residential	3551
Intensive Residential	Residential	3560
Community Residential	Residential	3570
Supportive Living	Residential	3580
Residential Services	Residential	3600
TREATMENT SUPPORT		
Job Placement Initiative	Treatment Support	0465
Case Management	Treatment Support	0810
Family Support Navigator	Treatment Support	0850
Local Governmental Unit (LGU) Administration	Treatment Support	0890
Peer Engagement	Treatment Support	0950
Vocational Rehabilitation	Treatment Support	4072
Support Services	Treatment Support	4080
Non-Medical Transportation	Treatment Support	4081
Capital Improvements	Treatment Support	4082
HIV Early Intervention Services	Treatment Support	4480
Dual Diagnosis Coordinator	Treatment Support	5990

0465 – Job Placement Initiative

Specialized job placement includes intensive and ongoing employment support services for individuals in recovery for substance use disorders. The individual must have a stated employment goal and seek support for a direct job placement in the competitive (minimum wage and hire) work environment. These support services are offered indefinitely by OASAS providers designated to offer individualized employment support services as per Home and Community Based Services (HCBS) guidelines.

Regulation: Not Applicable

Units of Service: None for CFR

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

0850 – Family Support Navigator

Family Support Navigators help individuals and their families to understand addiction as a progressive disease, identify types of available addiction services, and learn about the process of recovery. They also provide guidance on how to navigate insurance issues and access treatment services.

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

0950 – Peer Engagement

Peer engagement services are delivered by individuals who are in recovery or who have personal family experience with recovery. They have expertise in addiction and addiction services, allowing them to provide support, encouragement, and guidance to help link individuals to services based on their specific needs, circumstances, and recovery goals.

Regulation: Not Applicable

Units of Service: None for CFR

2030 – Residential Opioid Treatment

Opioid treatment programs (OTPs) that dispense methadone and other medication assisted treatment options, in conjunction with a variety of other rehabilitative assistance in a residential setting, to control the physical problems associated with opioid dependence and to provide the opportunity for patients to make major life-style changes over time.

Regulation: 822

Units of Service: Patient Days

2050 – Outpatient Opioid Treatment

Opioid treatment programs (OTPs) where methadone and other medication assisted treatment options are delivered on an ambulatory basis, with most programs located in either a community or hospital setting.

Comprehensive services, targeting individuals with primary Opioid Use Disorders along with other substance use disorders, medical, pharmacological, counseling, peer and other ancillary services.

Regulation: 822

Units of Service: Threshold Visits – each time a patient/collateral crosses the threshold of a facility to receive services at a certified site, without regard to the number of procedures provided during that visit. Count only one threshold visit per patient/collateral per day.

For OASAS Opioid Treatment Programs (OTP) billed under an Ambulatory Patient Group (APG), the facilities should report the number of threshold visits, not the weekly claims. For example, a patient has five threshold visits for the week in which methadone was dispensed and one weekly claim is submitted. Report the five threshold visits. Similarly, if a patient receives a 30-day take home dose in a threshold visit, report one threshold visit. OTP billing under APGs (rate codes 1564 and 1567), while billed weekly, receives a payment for each day during the week that has a patient interaction so each date of service on the weekly claim should be counted as a threshold visit. The OTP Bundles (rate codes 7969 – 7976) are billed and paid weekly regardless of the amount of patient-provider interaction during the week. Each billed week for those codes should be counted as a single threshold visit because there is only a single payment amount for each week.

2150 – KEEP Units Outpatient

Opioid treatment programs (OTPs) where medication assisted treatment is 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: 822

Units of Service: Threshold Visits – each time a patient/collateral crosses the threshold of a facility to receive services at a certified site, without regard to the number of procedures provided during that visit. Count only one threshold visit per patient/collateral per day.

For OASAS Opioid Treatment Programs (OTP) billed under an Ambulatory Patient Group (APG), the facilities should report the number of threshold visits, not the weekly claims. For example, a patient has five threshold visits for the week in which methadone was dispensed and one weekly claim is submitted. Report the five threshold visits. Similarly, if a patient receives a 30-day take home dose in a threshold visit, report one threshold visit. OTP billing under APGs (rate codes 1564 and 1567), while billed weekly, receives a payment for each day during the week that has a patient interaction so each date of service on the weekly claim should be counted as a threshold visit. The OTP Bundles (rate codes 7969 – 7976) are billed and paid weekly regardless of the amount of patient-provider interaction during the week. Each billed week for those codes should be counted as a single threshold visit because there is only a single payment amount for each week.

2230 – Children's HCBS Waiver Individualized Care Coordination

The intent of the Home and Community-Based Services (HCBS) Waiver, authorized in 1915(c) of the Social Security Act, is to maintain children with serious emotional disturbance (SED), who would otherwise be in hospital levels of care, in their homes and communities by reimbursing for non-traditional services. Individualized Care Coordination (ICC) includes services such as intake and screening, assessment of needs, service plan development, linking, advocacy, monitoring discharge planning and consultation.

Units of Service: Count each individual served during a month as one unit.

2250 – Children's HCBS Waiver Family Support

The intent of the Home and Community-Based Services (HCBS) Waiver, authorized in 1915(c) of the Social Security Act, is to maintain children with serious emotional disturbance (SED), who would otherwise be in hospital levels of care, in their homes and communities by reimbursing for non-traditional services. Family Support provides 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: Count each 15-minute billable unit as one unit.

2260 – Children's HCBS Waiver Crisis Response

The intent of the Home and Community-Based Services (HCBS) Waiver, authorized in 1915(c) of the Social Security Act, is to maintain children with serious emotional disturbance (SED), who would otherwise be in hospital levels of care, in their homes and communities by reimbursing for non-traditional services. Crisis Response provides activities aimed at stabilizing occurrence of child/family crisis when they arise.

Units of Service: Count each billable unit as one unit.

2270 – Children's HCBS Waiver Skill Building

The intent of the Home and Community-Based Services (HCBS) Waiver, authorized in 1915(c) of the Social Security Act, is to maintain children with serious emotional disturbance (SED), who would otherwise be in hospital levels of care, in their homes and communities by reimbursing for non-traditional services. Skill Building provides activities designed to assist the child in acquiring, developing and accessing functional skills and support-both social and environmental-needed to function more successfully in the community.

Units of Service: Count each 15-minute billable unit as one unit.

2280 – Children's HCBS Waiver Intensive In-Home

The intent of the Home and Community-Based Services (HCBS) Waiver, authorized in 1915(c) of the Social Security Act, is to maintain children with serious emotional disturbance (SED), who would otherwise be in hospital levels of care, in their homes and communities by reimbursing for non-traditional services. Intensive In-Home provides ongoing activities aimed at providing intensive interventions in the home when a crisis response service is not enough.

Units of Service: Count each billable unit as one unit.

2370 – Children's HCBS Waiver Youth Peer Advocate

The intent of the Home and Community-Based Services (HCBS) Waiver, authorized in 1915(c) of the Social Security Act, is to maintain children with serious emotional disturbance (SED), who would otherwise be in hospital levels of care, in their homes and communities by reimbursing for non-traditional services. Youth Peer Advocate (YPA) services offer positive youth development-centered services for waiver participants with a resiliency/recovery focus. Waiver YPA services are designed to support Waiver participants in the restoration and expansion of the skills and strategies necessary to move forward in meeting their personal, individualized life goals and to support their transitioning into adulthood. Waiver YPA services are planned to assist waiver participants with identifying and enhancing their strengths, supports (community and natural) and teach self-advocacy skills.

Units of Service: Count each 15-minute billable unit as one unit.

2710 – Problem Gambling Resource Center

Problem Gambling Resource Centers are the central hub within its defined geographical area that are responsible for the facilitation and coordination of problem gambling awareness, community education, prevention, treatment, and recovery support as well as collaborative efforts with legalized gambling facilities.

Regulation: Not Applicable

Units of Service: None for CFR

2780 – Problem Gambling Treatment

Provides outpatient treatment to problem gamblers designed to reduce symptoms, improve functioning and provide ongoing support. A problem gambling treatment program shall provide assessment, screening and referral for other problems, financial management planning, connection to self-help groups for problem gamblers, individual, group and family therapy specific to this diagnosis and crisis intervention.

Regulation: 822 and 857

Units of Service: Visits

2790 – Problem Gambling Prevention

Programs engage in 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

3039 – Medically Supervised Withdrawal Services - Inpatient

Medically Supervised Withdrawal Services can only be delivered by a provider of services certified by the Office to provide a continuum of care encompassing: residential, inpatient or outpatient substance use disorder treatment services in order to ensure appropriate continuation in treatment. Such services are appropriate for persons suffering from mild to moderate withdrawal, coupled with situational crisis such as unstable living environments, or who are unable to detox on their own without withdrawal complications.

These services include the medical supervision of persons undergoing moderate withdrawal or who are at risk of moderate withdrawal, who may be experiencing non-acute physical or psychiatric complications associated with their substance use disorder. The possible medical/psychiatric needs of this population require that the service provide sufficient on-site prescribing professional hours to oversee evaluations needed to prescribe any and all necessary medications to ensure safe withdrawal, as well as prescribing professional and nursing personnel available to all patients during all hours of observation.

Regulation: 816.7

Units of Service: Patient Days

3059 – Medically Supervised Withdrawal Services - Outpatient

Medically Supervised Outpatient services may only be delivered by an OASAS certified provider of residential, inpatient and outpatient services in order to assure appropriate continuation in treatment. Such services are appropriate for persons who are suffering from mild to moderate withdrawal of persons experiencing non-acute physical or psychiatric complications associated with their substance use disorder and who are unable to detox on their own without withdrawal complications, but who retain a stable living environment.

These services include medical supervision of persons undergoing mild to moderate withdrawal or persons experiencing non-acute physical or psychiatric complications associated with their substance use disorder, but who retain a stable living environment. Individuals in this service must be seen by a prescribing professional or registered nurse daily, unless otherwise specified by the overseeing physician. In addition, the provider of services must provide or make available a twenty-four (24) hour telephone crisis line to help facilitate the provision of this information.

Regulation: 816.8

Units of Service: Visits

3078 – Continuum of Care Rental Assistance Case Management

Provides Case Management to the HUD federally funded permanent supportive housing program. Dedicated supportive services to (chronically) homeless single adults and/or families, which include but are not limited to, counseling, referrals for education/vocational training, employment assistance, as well as assisting tenants in moving 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) assist communities, community prevention coalitions (CPCs) and NYS OASAS-funded prevention providers to implement evidence-based programs and strategies in New York State's substance use and problem gambling prevention infrastructure. PRCs serve as a key component in the transfer of knowledge to communities and prevention providers on current prevention science. They help facilitate partnerships and collaborations with a primary focus on building community prevention coalitions' capacity and resources in a multi-county area. PRCs operate regionally in the multiple counties/boroughs in their designated OASAS region.

Regulation: Not Applicable

Units of Service: None for CFR

3270 – NY NY III: Post-Treatment Housing

Permanent Supportive Housing opportunities combined with appropriate supportive services that meet the needs of homeless single adults who have completed some course of treatment for a substance use disorder and are at risk of street homelessness or sheltered homelessness and who need long-term supportive housing to sustain sobriety and recovery, as well as 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 families where the head of household has a substance use disorder that is a primary barrier to independent living.

Regulation: Not Applicable

Units of Service: None for CFR

3470 – Permanent Supported Housing

Permanent Supportive Housing opportunities combined with appropriate supportive services that meet the needs of individuals who have a substance use disorder and are a risk of street homelessness or sheltered homelessness, and who need permanent supportive housing to enable recovery and achievement of self-reliant independent living. Congregate and mixed-use affordable housing are single buildings to provide apartments of a size and character that conforms to applicable state and city laws, regulations, and in addition can provide housing for low-income community members. The permanent supportive housing units may be part of a larger mixed-use building. Scattered Site Housing are apartments, rented from private landlords, for the purposes of housing and serving the tenants who are the recipients of this program. The OASAS PSH program also includes the Governor's Empire State Supportive Housing Initiative, targeting housing for homeless families and individuals with various disabilities and documented life-challenges.

Regulation: Not Applicable

Units of Service: None for CFR

3480 – Permanent Supported Housing for High Frequency Medicaid Consumers

Housing opportunities combined with appropriate supportive services that meet the needs of individuals with addiction problems who are high frequency, high-cost Medicaid services consumers. Services include rental subsidies and other occupancy costs for apartments, housing counseling, and employment counseling.

Regulation: Not Applicable

Units of Service: None for CFR

3500 – Medically Managed Withdrawal and Stabilization Services

Unless otherwise authorized, Medically Managed Withdrawal and Stabilization Services can only be provided certified by OASAS and certified by the Department of Health as a general hospital. Such services are appropriate for individuals who are acutely ill from substance-related dependence, experiencing severe withdrawal or risk of severe withdrawal symptoms.

These services include medical management of acute intoxication and withdrawal services and require the use of an observation period for up to 48 hours of admission. Due to the acute medical conditions seen in this setting, these services require a Medical Director to oversee the provision of services. In addition, a physician must be on-call at all times, sufficient on-site prescribing professional hours to oversee evaluations needed to prescribe any and all necessary medications to ensure safe withdrawal, and registered nursing personnel immediately available to all patients all the time.

Regulation: 816.6

Units of Service: Patient Days

3510 – Medically Monitored Withdrawal and Stabilization Services

Medically Monitored Withdrawal and Stabilization Services are designed for persons who are suffering from mild withdrawal coupled with situational crisis, or who are unable to detox on their own without withdrawal complications. 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: 816.9

Units of Service: Patient Days

3520 – Medically Supervised Outpatient

A Medically Supervised Outpatient Clinic, including Intensive Outpatient Services (IOS) is intended for individuals who can maintain stability without the need for 24-hour supervision, live in an environment that is conducive to recovery, and have demonstrated functional skills for self-care. Intensive Outpatient Services are for those who need time limited intensive services (at least 3 hours a visit date) to solidify stability in preparation for longer term outpatient services. These individuals need more immediate assistance with drug refusal skills, immediate understanding/intervention regarding triggers to hazardous use.

Regulation: 822

Units of Service: Threshold Visits – each time a patient/collateral crosses the threshold of a facility to receive services at a certified site, without regard to the number of procedures provided during that visit. Count only one threshold visit per patient/collateral per day.

For OASAS Opioid Treatment Programs (OTP) billed under an Ambulatory Patient Group (APG), the facilities should report the number of threshold visits, not the weekly claims. For example, a patient has five threshold visits for the week in which methadone was dispensed and one weekly claim is submitted. Report the five threshold visits. Similarly, if a patient receives a 30-day take home dose in a threshold visit, report one threshold visit. OTP billing under APGs (rate codes 1564 and 1567), while billed weekly, receives a payment for each day during the week that has a patient interaction so each date of service on the weekly claim should be counted as a threshold visit. The OTP Bundles (rate codes 7969 – 7976) are billed and paid weekly regardless of the amount of patient-provider interaction during the week. Each billed week for those codes should be counted as a single threshold visit because there is only a single payment amount for each week.

3528 – Enhanced Medically Supervised Outpatient

These programs represent enhanced services or demonstration projects not required in all certified outpatient programs. Providers report funding separately from the outpatient program the enhancement is attached to as well as any programmatic reporting required for the specific activities or demonstration.

Regulation: Not Applicable

Units of Service: None for CFR

3530 – Outpatient Rehabilitation Services

Outpatient Rehabilitation provides a more intensive structured array of services to assist individuals who have limited functional skills, including self-care, nutrition, social connection, and recovery support. Services are provided in either 2-hour or 4-hour timeframes per service date 3 to 5 days per week. Individuals may move to the Outpatient Clinic level of care once they have acquired the skills to address their specific functional deficits.

Regulation: 822

Units of Service: Threshold Visits – each time a patient/collateral crosses the threshold of a facility to receive services at a certified site, without regard to the number of procedures provided during that visit. Count only one threshold visit per patient/collateral per day.

For OASAS Opioid Treatment Programs (OTP) billed under an Ambulatory Patient Group (APG), the facilities should report the number of threshold visits, not the weekly claims. For example, a patient has five threshold visits for the week in which methadone was dispensed and one weekly claim is submitted. Report the five threshold visits. Similarly, if a patient receives a 30-day take home dose in a threshold visit, report one threshold visit. OTP billing under APGs (rate codes 1564 and 1567), while billed weekly, receives a payment for each day during the week that has a patient interaction so each date of service on the weekly claim should be counted as a threshold visit. The OTP Bundles (rate codes 7969 – 7976) are billed and paid weekly regardless of the amount of patient-provider interaction during the week. Each billed week for those codes should be counted as a single threshold visit because there is only a single payment amount for each week.

3550 – Substance Use Disorder Inpatient Rehabilitation Services

Inpatient Rehabilitation Services are OASAS-certified 24-hour, structured, short-term, intensive treatment services provided in a hospital or free-standing facility. Such services are appropriate for individuals with substance use disorders who are not in need of medical detoxification or acute care and are unable to participate in, or comply with, treatment outside of a 24-hour structured treatment setting. They may have physical or psychiatric complications or are using substances in a way that puts them at eminent harm.

Treatment is provided under direction of a physician medical director and the staff includes nursing and clinical staff 24 hours 7 days per week. Activities are structured daily to improve cognitive and behavioral patterns and improve functioning to allow for the development of skills to manage chronic patterns of substance use and develop skills to cope with emotions and stress without return to substance use.

Regulation: 818

Units of Service: Patient Days

3551 – Residential Rehabilitation Services for Youth (RRSY)

Residential Rehabilitation Services for Youth provide stabilization and rehabilitation services for youth under the age of 21, who need residential treatment for a substance use disorder and/or a substance use disorder and a co-occurring mental health disorder. The program requires a multi-disciplinary team, to include a medical director and the appropriate psychological services, and access to medical services on a 24-hour basis. In an RRSY program, the multi-disciplinary team defined in Part 800 of OASAS' regulations have been 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 Days

3560 – Intensive Residential

These programs assist individuals who suffer from substance use disorder, who are unable to mention 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 substance use disorder inpatient services. In addition to individual counseling, group counseling, supportive services, educational services, structured daily activities and adult living skills. Intensive residential programs provide the following, either directly or by referral: medical, mental health, parenting, and vocational employment supports that include vocational assessment, job skills training and employment readiness. These programs provide a minimum of 40 hours/week of services within a therapeutic milieu.

Regulation: 819

Units of Service: Patient Days

3570 – Community Residential

This service provides a congregate living environment within a structured therapeutic milieu while residents are concurrently enrolled in an outpatient substance use disorder service which provides addiction counseling. Community residential programs provide the following services either directly or by linkage and referral to community providers of medical, mental health, parenting training, and vocational employment supports that include vocational assessment, job skills training and employment readiness. Individuals appropriate for this level of care include persons who are homeless or whose living environment that is not conducive to support recovery and maintain abstinence.

Regulation: 819

Units of Service: Patient Days

3580 – Supportive Living

A substance use disorder residential program designed to promote independent living in a supervised setting for individuals who have completed another course of treatment, and are making the transition to independent living, and whose need for service does not require twenty-four hour a day on-site staffing. Geared toward individuals who are in need of a transitional living environment prior to establishing independent community living.

Regulation: 819

Units of Service: Patient Days

3600 – Residential Services

Residential services are 24/7 structured treatment/recovery services to persons recovering from substance use disorders. Each Element of Care is distinguished by specific staffing and unique services provided which correspond to the degree of an individual's dysfunction. Services are aligned to the following elements of the treatment/recovery process:

1) Stabilization provides a safe environment in which a person may stabilize from mild to moderate withdrawal symptoms, severe cravings, psychiatric and medical symptoms and emotional crisis as well as acclimate to medications specific to individual needs before referral or transition to another program or element of structured treatment/recovery. Stabilization staffing requires the oversight of a physician, medical staff, psychiatrist and clinicians to monitor and meet the needs of this population.

2) Rehabilitation provides a structured environment for persons whose potential for independent living is seriously limited due significant functional impairment including the inability to follow social norms, these persons require a course of rehabilitative services specifically in the structured environment with staffing to provide monitoring, support and case management. Rehabilitation requires the oversight of a physician, medical staff, psychiatrist and clinicians to monitor and meet the needs of this population.

3) Reintegration provides a community living experience with limited supervision and case management services. Persons appropriate for this Element are transitioning to long-term recovery from substance use disorder and are working towards independent living in their community of origin. Reintegration providers offer linkage to Part 822 Outpatient services as well as Medical, Mental Health, Vocational Employment Supports and Recovery Wellness Supports. Reintegration services may be provided in a congregate setting or scattered site depending upon an individual's therapeutic needs. Congregate settings include 24-hour staff support while the individual receives services in the community whereas scatter site requires at least weekly staff contact to guide and monitor the individual while they access linkages to community services supporting long term recovery.

Regulation: 820

Units of Service: Patient Days

3920 – Youth Clubhouse

Youth Clubhouses provide a safe place for youth and young adults to develop pro-social skills that promote long-term health, wellness, recovery and a drug-free lifestyle in a community-based, non-clinical setting that is alcohol/drug-free. Youth Clubhouses promote long-term recovery through skill building, recreation, education, wellness, evidence-based prevention activities and a number of other pro-social activities and offer participants the opportunity to work with each other to achieve personal and common addiction recovery goals.

Regulation: Not Applicable

Units of Service: None for CFR

3970 – Recovery Community Centers

Recovery Community Centers (RCCs) provide peer-to-peer recovery support services to help people initiate and/or sustain recovery from alcohol and other substance use disorders. RCCs also provide support to family members of people needing, seeking, or in recovery from alcohol and other substance use disorders. The goal of these programs is to help persons in recovery sustain recovery on a long-term basis. To meet this goal, each RCC will provide needed emotional, informational, and social affiliation and instrumental (concrete) supports to persons in recovery, as well as to their families.

Regulation: Not Applicable

Units of Service: None for CFR

3980 – Recovery Community Organizing Initiative

The Recovery Community Organizing Initiative (RCOI) provides a broad range of services intended to support the building and mobilizing of strong grass-roots recovery organizations across New York State. The RCOI will establish the means to effectively communicate with these communities of recovery to educate professionals, policy makers and the general public about recovery related matters; support research and study to build a better understanding of recovery; and enhance the variety, availability, and quality of prevention, treatment and recovery supports.

Regulation: Not Applicable

Units of Service: None for CFR

4045 – Specialized Services Substance Abuse Programs

Specialized chemical dependence services not defined in other regulations that must be provided in accordance with the OASAS rules, regulations, and requirements.

Regulation: 824

Units of Service: None for CFR

4072 – Vocational Rehabilitation

Vocational Rehabilitation (VR) counseling support services are offered by qualified VR Counselors to provide six (6) federal VR benchmark service activities that include an individualized person-centered support and counseling process towards obtaining employment. VR services support individuals with a stated employment goal while enrolled in treatment for substance use disorders. VR counseling support services includes counseling, pre-vocational activities, training, educational services, employability skill building referrals experiences, as well as transitional skill building referrals and placement activities. VR counselors also offer intensive and ongoing employment support services for individuals who are new to employment or who need specific supports to maintain employment or pursue goals that support long term employment. Many of these services are offered in coordination with NY SED ACCESS-VR Regional Offices.

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

4080 – Support Services

Chemical dependence related support services for OASAS programs.

Regulation: Not Applicable

Units of Service: None for CFR

4081 – Non-Medical Transportation

Non-medical transportation for people who use substances or are in recovery from substance use, receive recovery, harm reduction and/or treatment services and for whom transportation will support individualized recovery goals. Non-medical needs include recreational activities likely to increase social connection or emotional well-being, recovery supports, peer interactions, formal or informal mutual support groups such as SMART (Self-Management and Recovery Training) recovery and AA (Alcoholics Anonymous) or NA (Narcotics Anonymous) meetings, rides to treatment or harm reduction services or to service providers (when no medical transportation is available).

Regulation: Not Applicable

Units of Service: None for CFR

4082 – Capital Improvements

Minor alterations and improvements to fixed equipment and/or physical plant of OASAS program facilities in accordance with OASAS guidelines.

Regulation: Not Applicable

Units of Service: None for CFR

4480 – HIV Early Intervention Services

HIV Early Intervention Services (EIS) such as testing, pre- and post-test counseling, awareness/education sessions, and referrals to HIV/AIDS medical care. HIV EIS services are provided at an OASAS-certified program to individuals actively seeking treatment for a substance abuse disorder.

Regulation: Not Applicable

Units of Service: None for CFR

4610 – Adult Behavioral Health Home and Community Based Services (BH HCBS) Ongoing Supported Employment (OSE)

This service is provided after a participant successfully obtains and becomes oriented to competitive and integrated employment. Ongoing follow-along is support available for an indefinite period as needed by the participant to maintain their paid employment position. Individual employment support services are individualized, person centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

Units of Service: 15 Minutes.

4620 – Adult Behavioral Health Home and Community Based Services (BH HCBS) Intensive Supported Employment (ISE)

ISE services assist individuals with individuals with mental health (MH) or substance use disorders (SUD) to obtain and keep competitive employment. These services consist of intensive supports that enable individuals to obtain and keep competitive employment at or above the minimum wage. This service will follow the evidence-based principles of the Individual Placement and Support (IPS) model. This service is based on IPS model which is an evidence-based practice of supported employment. It consists of intensive supports that enable individuals for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their clinical and functional needs, require supports to perform in a regular work setting. Individual employment support services are individualized, person-centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support. Services that consist of intensive supports that enable participants for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their disabilities, need supports to perform in a regular work setting.

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

Units of Service: 15 Minutes.

4630 – Adult Behavioral Health Home and Community Based Services (BH HCBS) Transitional Employment

This service is designed to strengthen the participant'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. This service is provided, instead of individual supported employment, only when the person specifically chooses this service and may only be provided by clubhouse, psychosocial club program certified provider or recovery center. This service specifically provides learning and work experiences where the individual with behavioral health and/or substance use disorders can develop general, non-job-task-specific strengths and soft skills that contribute to employability in the competitive work environment in integrated community settings paying at or above minimum wage. The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

Units of Service: 15 Minutes.

4640 – Adult Behavioral Health Home and Community Based Services (BH HCBS) Pre-Vocational Services

Pre-vocational services are time-limited services that prepare a participant for paid or unpaid employment. This service specifically provides learning and work experiences where the individual with mental health and/or disabling substance use disorders can develop general, non-job-task specific strengths and soft skills that that contribute to employability in competitive work environment as well as in the integrated community settings. Pre-vocational services occur over a defined period of time and with specific person-centered goals to be developed and achieved, as determined by the individual and his/her employment specialist and support team and ongoing person-centered planning process as identified in the individual's person-centered plan of care. Pre-vocational services provide supports to individuals who need ongoing support to learn a new job and/or maintain a job in a competitive work environment or a self-employment arrangement. The outcome of this pre-vocational activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

Units of Service: Direct Care/Service Hours

4650 – CORE Empowerment Services - Peer Supports (Non-Licensed Program)

Empowerment Services (Peer Support) are non-clinical, peer-delivered services with focus on rehabilitation, recovery, and resilience. They are designed to promote skills for coping with and managing behavioral health symptoms while facilitating the utilization of natural supports and community resources.

Peer support must include the identified goals or objectives in the member's individualized service plan, with interventions tailored to the individual. These goals should promote utilization of natural supports and community services, supporting the person's recovery and enhancing the quality of their personal and family life. The intentional, goal-directed activities provided by this service emphasize the opportunity for peers to model skills and strategies necessary for recovery, thereby developing the individual's skills and self-efficacy. These services are provided through the perspective of a shared personal experience of recovery, enhancing the individual's sense of empowerment and hope.

CORE services are only available to individuals in a HARP or HIV SNP, and who have been recommended for CORE services by a Licensed Practitioner of the Healing Arts (LPHA).

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

Units of Service: 15 Minutes.

4660 – Adult Behavioral Health Home and Community Based Services (BH HCBS) Education Support Services (ESS)

Education Support Services are provided to assist individuals with mental health or substance use disorders who want to start or return to school or formal training with a goal of achieving skills necessary to obtain employment. Education Support Services consist of special education and related services as defined in Sections (22) and (25) of the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) (20 U.S.C. 1401 et seq.), to the extent to which they are not available under a program funded by IDEA or available for funding by the NYS Adult Career and Continuing Education Services Office of Vocational Rehabilitation (ACCES-VR) (The Vocational Rehabilitation component (ACCES-VR) encompasses many of the services that were previously part of Vocational and Educational Services for Individuals with Disabilities, or VESID).

Education Support Services may consist of general adult educational services such as applying for and attending community college, university or other college-level courses. Services may also include classes, vocational training, and tutoring to receive a Test Assessing Secondary Completion (TASC) diploma, as well as support to the participant to participate in an apprenticeship program.

Participants authorized for Education Support Services must relate to an employment goal or skill development documented in the service plan. Education Support Services must be specified in the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. Examples of these goals would include, but not be limited to: tutoring or formal classes to obtain a Test Assessing Secondary Completion (TASC) diploma, vocational training, apprenticeship program or formal classes to improve skills or knowledge in a chosen career, community college, university or any college-level courses or classes.

Ongoing Supported Education: is conducted after a participant is successfully admitted to an educational program. Ongoing follow-along is support available for an indefinite period as needed by the participant to maintain their status as a registered student.

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

Units of Service: Direct Care/Service Hours

4670 – Adult Behavioral Health Home and Community Based Services (BH HCBS) Intensive Crisis Respite (ICR)

Intensive Crisis Respite (ICR) is a short-term, residential care and clinical intervention strategy for individuals who are facing a behavioral health crisis, including individuals who are suicidal, express homicidal ideation, or have a mental health or co-occurring diagnosis and are experiencing acute escalation of mental health symptoms. In addition, the person must be able to contract for safety.

Individuals in need of ICR are at imminent risk for loss of functional abilities and may raise safety concerns for themselves and others without this level of care. The immediate goal of ICR is to provide supports to help the individual stabilize and return to previous level of functioning or as a step-down from inpatient hospitalization.

BH HCBS services are only available to individuals enrolled in a HARP or HIV SNP, who have been approved for HCBS services in their plan of care.

- Individuals must have an acute medical condition requiring higher level of care.
- 7 days maximum per episode.
- Intensive Crisis Respite services include a limit of 21 days per year. Individuals requiring Intensive Crisis Respite for longer periods than those specified may be evaluated on an individual basis and approved for greater length of stay based on medical necessity.

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

Units of Service: Resident Days

4680 – Adult Behavioral Health Home and Community Based Services (BH HCBS) Short-Term Crisis Respite

Short-term Crisis Respite is a short-term care and intervention strategy for individuals who have a mental health or co-occurring diagnosis and are experiencing challenges in daily life that create risk for an escalation of symptoms that cannot be managed in the person's home and community environment without onsite supports including:

- A mental health or co-occurring diagnosis and are experiencing challenges in daily life that create imminent risk for an escalation of symptoms and/or a loss of adult role functioning but who do not pose an imminent risk to the safety of themselves or others.
- A challenging emotional crisis occurs which the individual is unable to manage without intensive assistance and support.
- When there is an indication that a person's symptoms are beginning to escalate.

Referrals to Crisis Respite may come from the emergency room, the community, self-referrals, a treatment team, or as part of a step-down plan from an inpatient setting. Crisis respite is provided in site-based residential settings. Crisis Respite is not intended as a substitute for permanent housing arrangements.

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

Units of Service: Resident Days

4690 – CORE Family Support and Training (FST) (Non-Licensed Program)

Family Support and Training offers instruction, emotional support, and skill building necessary to facilitate engagement and active participation of the family in the individual's recovery process. The FST practitioner partners with families through a person-centered or person-directed, recovery oriented, trauma-informed approach.

Family is defined as the individual's family of choice. This may include persons who live with or provide support to a person, such as a parent, spouse, significant other, children, relatives, foster family, or in-laws. Family does not include individuals who are employed to care for the participant.

CORE services are only available to individuals enrolled in a HARP or HIV SNP, and who have been recommended for CORE services by a Licensed Practitioner of the Healing Arts (LPHA).

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

Units of Service: 15 Minutes.

4700 – Adult Behavioral Health Home and Community Based Services (BH HCBS) Habilitation

Habilitation services are typically provided on a 1:1 basis and are designed to assist participants with a behavioral health diagnosis (i.e. substance use disorder (SUD) or mental health) in acquiring, retaining and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources and adaptive skills necessary to reside successfully in home and community-based settings. These services assist participants with developing skills necessary for community living and, if applicable, to continue the process of recovery from a SUD disorder. Services include things such as: instruction in accessing transportation, shopping and performing other necessary activities of community and civic life including self-advocacy, locating housing, working with landlords and roommates and budgeting. Services are designed to enable the participant to integrate full into the community and endure recovery, health, welfare, safety and maximum independence of the participant.

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

Units of Service: 15 Minutes.

4710 – CORE Psychosocial Rehabilitation (PSR) (Non-Licensed Program)

Psychosocial Rehabilitation (PSR) is designed to assist an individual in improving their functional abilities to the greatest degree possible in settings where they live, work, learn, and socialize. Rehabilitation counseling, skill building, and psychoeducational interventions provided through PSR are used to support attainment of person-centered recovery goals and valued life roles. Approaches are intended to develop skills to overcome barriers caused by a participant's behavioral health disorder and promote independence and full community participation. CORE PSR will incorporate allowable service components of Adult BH HCBS education, vocational, and habilitation services.

CORE services are only available to individuals enrolled in a HARP or HIV SNP, and who have been recommended for CORE services by a Licensed Practitioner of the Healing Arts (LPHA).

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

Units of Service: 15 Minutes.

4720 – CORE Community Psychiatric Support and Treatment (CPST) (Non-Licensed Program)

CPST includes time-limited, goal-directed supports and solution-focused interventions with the intent to achieve person-centered goals and objectives. This is a multi-component service that consists of therapeutic interventions such as clinical counseling and therapy, which assist the consumer in achieving stability and functional improvement in the following areas: daily living, finances, housing, education, employment, personal recovery and/or resilience, family and interpersonal relationships and community participation. CPST is designed to provide mobile treatment services to individuals who have difficulty engaging in site-based programs, or who have not been previously engaged in services, including those who had only partially benefited from traditional treatment. CPST allows for delivery of services within a variety of permissible off-site settings including, but not limited to, community locations where the individual lives, works, learns, and/or socializes.

CORE services are only available to individuals enrolled in a HARP or HIV SNP, and who have been recommended for CORE services by a Licensed Practitioner of the Healing Arts.

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

Units of Service: 15 Minutes.

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

4900 – Children & Family Treatment & Support Services: Family Peer Support Services (FPSS) (Non-Certified Program)

As a Medicaid funded Children's Health and Behavioral Health Services program, FPSS are an array of formal and informal activities and supports provided to families caring for/raising a child who is experiencing social, emotional, medical, developmental, substance use and/or behavior challenges in his/her life. FPSS provide a structured, strength-based relationship between a Family Peer Advocate (FPA) and the parent/family member/caregiver for the benefit of the child/youth. The need for this service must be determined by a licensed practitioner and included within a treatment plan. Family is defined as the primary care-giving unit and is inclusive of the wide diversity of primary caregiving units in our culture. Service components include activities to help the families to develop resources and supports for the benefit of the child/youth, including engagement, bridging and transition, self-advocacy, self-efficacy and empowerment, parent skill development, and community connections. Please reference the Medicaid State Plan Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Testing (EPSDT) Services for definitions of service components and staffing requirements.

This program is effective 07/01/2018 for services provided in NYC, and effective 01/01/2019 for services provided in the rest of the state.

Units of Service: Count the number of visits.

4910 – Children & Family Treatment & Support Services: Mobile Crisis Intervention (CI) (Non-Certified Program)

As a Medicaid funded Children's Health and Behavioral Health Services program, CI services are mobile services provided to children/youth under age 21 who are identified as experiencing acute psychological/emotional change which results in a marked increase in personal distress, and which exceeds the abilities and resources involved to resolve it effectively. CI is a face-to-face intervention that can occur in a variety of settings. CI services are available 24 hours per day, seven days per week and respond within 1 hour of the completion of the initial call to the crisis provider, and upon determination that an in-person contact is required. Services are provided through a multi-disciplinary team to enhance engagement and meet the unique needs of the child/youth and family. The team must be comprised of at least two professionals and one of these two must be a licensed behavioral health professional with crisis intervention service delivery experience. Please reference the Medicaid State Plan Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Testing (EPSDT) Services for specific service components and staffing requirements.

This program is effective 07/01/2018 for services provided in NYC, and effective 01/01/2019 for services provided in the rest of the state.

Units of Service: Count the number of visits.

4920 – Children & Family Treatment & Support Services: Youth Peer Support (YPS) (Non-Certified Program)

As one of the six Medicaid Funded Children's Health and Behavioral Health Services, YPS services are formal and informal services designed to support youth who are experiencing social, medical, emotional, developmental, substance use, and/or behavioral challenges in their home or community. The service provides the support necessary to encourage engagement and active participation of the youth in the treatment planning process and with the ongoing implementation and reinforcement of skills. The service is delivered by a Credentialed Youth Peer Advocate (CYPA), who must be 18 to 30 years old and has self-identified as a person who has first-hand experience with social, emotional, medical, developmental, substance use, and/or behavioral challenges. The need for this service must be determined by a licensed practitioner and included within a treatment plan. Service components include activities to help the youths to achieve functional improvement, including skill building, coaching, engagement, bridging and transition support, self-advocacy, self-efficacy and empowerment, and community connections and natural support. Please reference the Medicaid State Plan Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Testing (EPSDT) Services for definitions of service components and state requirements.

This program is effective 07/01/2018 for services provided in NYC, and effective 01/01/2019 for services provided in the rest of the state.

Units of Service: Count the number of visits.

4930 – Children & Family Treatment & Support Services: Psychosocial Rehabilitation (PSR) (Non-Certified Program)

As a Medicaid funded Children's Health and Behavioral Health Services program, PSR services are designed to restore, rehabilitate, and support a child's/youth's developmentally appropriate functioning as necessary for the integration of the child/youth as an active and productive member of his/her family and community with the goal of achieving minimal on-going professional intervention. Activities are "hands on" and task oriented, intended to achieve the identified goals or objectives as set forth in the child/youth's individualized treatment plan. Service components include skill development to support personal and community competence, including social and interpersonal skills, daily living skills, and community integration. Please reference the Medicaid State Plan Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Testing (EPSDT) Services for definitions of service components and staffing requirements.

PSR services are to be recommended by a licensed practitioner and as part of a treatment plan. PSR activities are focused on addressing the rehabilitative needs of the child/youth as part of a treatment plan and can be provided in coordination with treatment interventions by a licensed practitioner (e.g. OLP) or provider of community psychiatric support and treatment (CPST).

This program is effective 07/01/2018 for services provided in NYC, and effective 01/01/2019 for services provided in the rest of the state.

Units of Service: Count the number of visits.

4940 – Children & Family Treatment & Support Services: Other Licensed Practitioner (OLP) (Non-Certified Program)

As a Medicaid funded Children's Health and Behavioral Health Services program, OLP consists of three different service components: evaluation, counseling, and crisis. Service components include licensed evaluation (assessment); psychotherapy (counseling); and crisis intervention. OLP is performed by an individual who is licensed in NYS to diagnose, and/or treat individuals with a physical illness, mental illness, substance use disorder, or functional limitations at issue, operating within the scope of practice defined in NYS law and in any setting permissible under State law. OLP services can be provided to individuals, families, or groups, and can be provided on-site or off-site. Please reference the Medicaid State Plan Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Testing (EPSDT) Services for definitions of service components and staffing requirements.

This program is effective 07/01/2018 for services provided in NYC, and effective 01/01/2019 for services provided in the rest of the state.

Units of Service: Count the number of visits.

4950 – Children & Family Treatment & Support Services: Community Psychiatric Support and Treatment (CPST) (Non-Certified Program)

As a Medicaid funded Children's Health and Behavioral Health Services program, CPST services are goal-oriented supports and solution-focused interventions intended to address challenges associated with a behavioral health need and to achieve identified goals or objectives from the child's treatment plan. CPST is a face-to-face intervention with the child/youth (required), family/caregiver or other collateral supports. Service components include intensive interventions, crisis avoidance and management, rehabilitative psychoeducation, strengths-based service planning and rehabilitative supports. Please reference the Medicaid State Plan Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Testing (EPSDT) Services for definitions of service components and staffing requirements.

This program is effective 07/01/2018 for services provided in NYC, and effective 01/01/2019 for services provided in the rest of the state.

Units of Service: Count the number of visits.

5520 – Primary Prevention Services

Primary Prevention is defined as a collaborative and community focused process to prevent or delay substance use and abuse in individuals, families and communities. Prevention service approaches include education, environmental strategies, community capacity building, positive alternatives and information dissemination. The selection of prevention service activities within these service approaches is based on a community needs assessment that identifies levels of substance use, its consequences, elevated risk factors and decreased protective factors. Prevention counseling and early intervention activities with individuals, families and groups are not included as Primary Prevention Services. Individuals who are diagnosable for substance abuse or dependence are not served with Primary Prevention Services. Detailed descriptions of the risk and protective factors for substance abuse, service approaches and activities may be found in the OASAS 2011 Prevention Guidelines.

Regulation: Not Applicable

Units of Service: None for CFR

5550 – Other Prevention Services

Other Prevention service approaches funded by OASAS include Prevention Counseling and Early Intervention. Prevention Counseling is an OASAS certified service designed to assess and improve the levels of youth and family risk and protective factors to prevent or reduce substance use, problem gambling and the negative consequences of such behaviors. Prevention Counseling is offered to IOM selected youth who are considered at highest risk for developing substance abuse or gambling problems. Early Intervention is offered to IOM Indicated individuals who have already begun to exhibit substance use or gambling behaviors but do not meet the DSM-IV criteria of substance abuse or dependence or problem gambling. Individuals may require referral for assessment and treatment with more intensive services. Complete descriptions, policies and procedures, and service approaches for Prevention Counseling and Early Intervention may be found in the OASAS 2011 Prevention Guidelines.

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 –Residential Opioid Treatment to Abstinence

Opioid treatment programs (OTPs) where medication assisted treatment is delivered in a residential setting in gradually decreasing doses to the point of abstinence, followed by continued drug-free treatment.

Regulation: 822

Units of Service: Patient Days

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):

- *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.

- 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 Supportive 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 CFRS Web 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 CFRS Web. 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 CFRS Web 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-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
988 Crisis Hotline Center	1720
Adult Behavioral Health Home and Community Based Services (BH HCBS) Education Support Services (ESS) (Non-Licensed Program)	4660
Adult Behavioral Health Home and Community Based Services (BH HCBS) Habilitation (Non-Licensed Program)	4700
Adult Behavioral Health Home and Community Based Services (BH HCBS) Intensive Crisis Respite (ICR) (Non-Licensed Program)	4670
Adult Behavioral Health Home and Community Based Services (BH HCBS) Intensive Supported Employment (ISE) (Non-Licensed Program)	4620
Adult Behavioral Health Home and Community Based Services (BH HCBS) Ongoing Supported Employment (OSE) (Non-Licensed Program)	4610
Adult Behavioral Health Home and Community Based Services (BH HCBS) Pre-Vocational Services (Non-Licensed Program)	4640
Adult Behavioral Health Home and Community Based Services (BH HCBS) Self-Directed Care (Non-Licensed Program)	4740
Adult Behavioral Health Home and Community Based Services (BH HCBS) Short-Term Crisis Respite (Non-Licensed Program)	4680
Adult Behavioral Health Home and Community Based Services (BH HCBS) Transitional Employment (Non-Licensed Program)	4630
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 Service Dollars	0920
Children & Family Treatment & Support Services: Family Peer Support Services (FPSS)	4900
Children & Family Treatment & Support Services: Mobile Crisis Intervention (CI)	4910
Children & Family Treatment & Support Services: Youth Peer Support (YPS)	4920
Children & Family Treatment & Support Services: Psychosocial Rehabilitation (PSR)	4930
Children & Family Treatment & Support Services: Other Licensed Practitioner (OLP)	4940
Children & Family Treatment & Support Services: Community Psychiatric Support and Treatment (CPST)	4950
Children & Youth Assertive Community Treatment (Licensed Program)	4800
Children's HCBS Waiver Crisis Response	2260
Children's HCBS Waiver Family Support	2250
Children's HCBS Waiver Individualized Care Coordination	2230
Children's HCBS Waiver Intensive In-Home	2280
Children's HCBS Waiver Skill Building	2270
Children's HCBS Waiver Youth Peer Advocate	2370
Clinic Treatment	2100
Community Residence, Children & Youth	7050
Community Residence for Eating Disorder Integrated Treatment Program (CREDIT)	6110

Program Type	Program Code
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
CORE Community Psychiatric Support and Treatment (CPST) (Non-Licensed Program)	4720
CORE Empowerment Services – Peer Supports (Non-Licensed Program)	4650
CORE Family Support and Training (FST) (Non-Licensed Program)	4690
CORE Psychosocial Rehabilitation (PSR) (Non-Licensed Program)	4710
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
Family Based Treatment Program	2040
Family Care	0040
Family Peer Support Services (Children and 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
Health Home Care Management	2730
Health Home Care Management Service Dollar Administration	2850
Health Home Care Management Service Dollars	2740
Health Home Non-Medicaid Care Management	2620
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
Intensive Crisis Stabilization Center	1710
Intensive Psychiatric Rehabilitation Treatment (IPRT)	2320
Local Governmental Unit (LGU) Administration	0890
Local Governmental Unit (LGU) Administration - Reinvestment and Medication Grant Program (MGP) – OMH Only	0860
MICA Network	5990
Mobile Crisis Services	0680
Monitoring and Evaluation, CSS	0870
Multicultural Initiative	3990
Non-Medicaid Care Coordination	2720
Ongoing Integrated Supported Employment Services	4340
On-Site Rehabilitation	0320
OnTrackNY Coordinated Specialty Care First Episode Psychosis Program (Non-Licensed Program)	5010
Outreach	0690
Partial Hospitalization	2200

Program Type	Program Code
Permanent Housing Program (PHP)	1070
Promises Zone	1530
PROS Rehabilitation and Support Subcontract Services	9340
Psychosocial Club	0770
Recovery Center	2750
Recreation and/or Fitness	0610
Residential Crisis Support	5030
Residential Treatment Facility – Children & Youth	1080
Residential Treatment Facility (RTF) Transition Coordinator	2880
Respite Services	0650
RTF Service Dollars	2980
School Mental Health Program	1510
SCM Service Dollars	6910
Shelter Plus Care Housing (when funds flow through OMH, use 2070 when they do not)	3070
Single Point of Access (SPOA)	1400
Special Legislative Grant	1190
Specialty Mental Health Care Management	0780
Support Apartment	7080
Support Congregate	6080
Supported Education	5340
Supportive Crisis Stabilization Center	1700
Supportive Housing	6060
Supportive Single Room Occupancy (SP-SRO)	5070
Supportive Case Management (SCM)	6810
Teaching Family Home	4040
Transition Management Services	1970
Transformed Business Model	6140
Transitional Employment Placement (TEP)	0380
Transportation	0670
Treatment Apartment	7070
Treatment Congregate	6070
Vocational and Educational 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.

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

While exploring various types of employment opportunities through short term placements, an individual (age 18+) is able to strengthen his/her work skills and record, with the express goal of achieving assisted or unassisted competitive employment in a field the person selects. TEP provides 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 while addressing the person's mental health challenges. Financial/Benefits Counseling may be provided. If ongoing supports* are needed to sustain an employment situation found via the TEP process, these funds can continue to be used for this purpose. *Supports may include assisting someone in interpreting and responding appropriately to interpersonal situations at work or learning new coping skills designed to enhance their performance at work while coping with mental health symptoms.

The goal of supported employment is for individuals to work a minimum of 10 hours per week in an integrated, competitive job, with leeway for absence due to illness, vacation, or temporary work stoppages. To be considered employed part time, participants should be scheduled to work a minimum of 10 hours each week.

Individuals who are scheduled to work less than 10 hours per week or participate in a volunteer position with the express purpose of obtaining employment can be served in a TEP program though they do not meet the definition of being employed in a competitive, integrated setting. See Glossary for definitions of "Competitive Employment" and "Integrated Employment".

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)

For adults, Respite Services are temporary services (not beds) provided by trained staff in the consumer's place of residence or other temporary housing arrangement. It 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 adult consumer per year are 14 days.

For children and youth, Respite Services provide a needed break for the family and the child to ease the stress at home and promote overall wellness for the child and his/her family. Respite Services' activities include providing supervision and recreational activities that match the child's developmental stage and/or community outings with child, e.g., school, appointment or a program. Respite care may be provided on a planned or emergency basis, day or night, in the child's home or in the community by trained respite workers with one child or group of children.

Units of Service: Count the total number of 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.

0680 – Mobile Crisis Services
(Non-Licensed Program)

Mobile Crisis Services are specific activities that are provided by a mobile crisis intervention team that has been approved/designated by NYS to provide services to adults, 21 years and older to reduce acute psychiatric symptoms, restore individuals to pre-crisis level of functioning, make connections with community supports or secure access to a higher level of care when needed. Services include telephonic triage and response, mobile crisis services, telephonic crisis follow up and mobile crisis follow up. This code should not be used for CPEP crisis outreach (1680) or CFTSS Crisis Intervention (4910).

Units of Service: Count the number of visits.

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).

0780 – Specialty Mental Health Care Management (Non-Licensed Program)

OMH designated Specialty Mental Health Care Management programs, administered by Specialty Mental Health Care Management Agencies (SMH CMAs) provide services to the Health Home Plus (HH+) population. HH+ is an intensive level of Health Home Care Management provided to defined high-need adult populations with serious mental illness who are enrolled in a Health Home (HH) serving adults. To ensure the intensive needs of these individuals are met, SMH CMs must assure HH+ individuals receive a level of service consistent with the requirements outlined in the Health Home Plus for High-Need Individuals with Serious Mental Illness Program Guidance. The differential monthly rate for HH+ is higher compared to the Health Home High Risk/Need Care Management and Health Home Care Management rates and is intended to appropriately reimburse for the intense and consistent support needed for this population.

This program is effective 07/01/2021 for services provided in NYC, and effective 01/01/2021 for services provided in the rest of the state.

Units of Service: Report year end sum of the total persons served per month.

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.

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. 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). This program code can only be used with funding source code 001A on the OMH-specific claiming schedules. Note: This program type is exempt from the Ratio Value allocation of agency administration.

Units of Service: Not applicable.

0910 – Children's Crisis Residence
(Licensed Program)

The purpose of a Children's Crisis Residence Program (CCR) is to stabilize a child's psychiatric crisis symptoms and restore the child to a level of functioning and stability that supports their transition to community-based services, supports and resources to prevent or reduce future psychiatric crises. The crisis residence provides 24/7 monitoring and supervision for children ages 5-20 as well as intensive crisis treatment and support for the child, including support for family and caregivers to facilitate the child's successful return to home and/or community. Children may stay for up to 21 days.

The program is licensed for children under 14NYCRR589.

Units of Service: One resident day.

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 facilities 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:
- Half Day
- Full Day

Please refer to 14 NYCRR 588.7 for specific details on how these units are calculated.

1320 – Vocational and Educational Services - Children and Family
(Non-Licensed Program)

The Vocational Program for Adolescents was designed to provide work training and clinical support services for those youth 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.

1380 – Assisted Competitive Employment
(Non-Licensed Program)

ACE services may include brief pre-vocational support along with ongoing mental health supports in order to obtain and sustain integrated, competitive employment, or support for promotion or to find new employment. This program is for individuals not receiving ACCES-VR Employment services.

ACE provides these individuals with vocational rehabilitation and support services, both at the work site and off-site, while addressing challenges due to the person's mental health issues. Evidence based practices such as IPS (Individualized Placement and Supports) are recommended. Financial/Benefits Counseling may be provided.

The goal of supported employment is for individuals to work a minimum of 10 hours per week in an integrated, competitive job, with leeway for absence due to illness, vacation, or temporary work stoppages. See Glossary for definitions of "Competitive Employment" and "Integrated Employment". To be considered employed part time, participants should be scheduled to work a minimum of 10 hours each week.

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 a geriatric mobile outreach program designed to proactively identify at-risk older adults in the community who are not connected to the service delivery system. Staff is 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, and upon identification of an older adult in need, staff is able to engage and initiate an individual's in-home assessment and provide or access a variety of supportive services. The program is designed to keep at-risk seniors in their own homes and prevent premature out-of-home placement by addressing unmet needs. Services provided by a licensed outpatient program and/or services provided by another active OMH-funded program should not be reported under this program type and code. This program is associated with a grant under the Request for Proposal (RFP) titled "Partnership Innovation for Older Adults."

Units of Service: Count the total number of contacts, both primary and collateral, with no time threshold, which may be face-to-face, by phone, or through other technological means permitted in the RFP.

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 Mental Health Program
(Non-Licensed Program if reported under this code)

Services are provided for children and adolescents with emotional/behavioral needs in schools. Program services include a range of supportive activities related to the mental health needs of children, adolescents and families such as referrals to, and coordination of, services with other in-school or community-based providers; screening for mental health concerns and consultation with families; participation on school intervention teams and other school committees addressing the health, safety and well-being of children and adolescents; collaboration with school health and social work staff; support groups for families; participation in school events such as parent orientations and health fairs; after school programming; and other related activities. Services are in addition to those provided under a Clinic Treatment license and can be provided to students not enrolled in a Clinic Treatment program.

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

Units of Service: Staff hours.

1530 – Promises Zone
(Non-Licensed Program)

Promise Zones provide the framework for expanded access to mental health services in schools through school-community collaborations among mental health, local school districts, and state and local child/family-serving partners. The program includes three major components:

- An external change partner who serves as a coach for the success of the project and coordinates community resources;
- The school support team and school social worker;
- A community services support network.

Services include those provided to children and adolescents with emotional/behavioral needs in a school setting as well as related supports provided to targeted youth and their families and school staff. Family support services may be provided by a local family support organization with which the program contracts. Additional program services include, but are not limited to, consultation with school staff and families; training in the use of evidence-based practices; referrals to and coordination of services with other in-school or community-based providers; participation on Promise Zone school support team(s) and community services support team(s); collaboration with school health and pupil personnel services staff; support groups for families; and participation in school events, such as parent orientations and health fairs; after school programming, and other related activities. Funds may not be used to supplant school guidance, social work or psychology services and staff or community services of other system partners.

Units of Service: 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 Peer Support Services (Children and Family)
(Non-Licensed Program)

Family Peer Support Services (FPSS) are an array of formal and informal services and supports provided to families raising a child who is experiencing social, emotional, developmental, substance use and/or behavioral challenges in their home, school, placement, or community. FPSS provide a structured, strength-based relationship between a Family Peer Advocate and the parent or family member for the benefit of the child. For the purposes of this service, "family" is defined as the persons who live with, or provide care to, a child and may include a parent, spouse, sibling, children, relatives, grandparents, guardians, foster parents or others with significant attachment to the individual.

FPSS are provided by a trained and credentialed Family Peer Advocate (FPA) who is uniquely qualified to work with families based on their personal experience parenting a child with similar needs. FPSS can be provided through individual and group face-to-face work (at the family's home, in the community or in an office) or by video conferencing with face-to-face interface. Categories of FPSS include:

- Outreach and Information
- Engagement, Bridging and Transition Support
- Self-Advocacy, Self-Efficacy and Empowerment
- Parent Skill Development
- Community Connections and Natural Supports
- Promoting Effective Family-Driven Practice

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

1700 – Supportive Crisis Stabilization Center
(Licensed Program)

A Supportive Crisis Stabilization Center (SCSC) provides support and assistance to children and adults experiencing a mental health and/or substance use crisis. SCSC services are for recipients experiencing challenges in daily life that do not pose the likelihood of serious harm to self or others. Such challenges may create risk for an escalation of behavioral health symptoms that cannot reasonably be managed in the recipient's home and/or community environment without on-site supports. The SCSC provides voluntary services with an emphasis on peer and recovery support. SCSCs will provide, or contract to provide all SCSC services on-site, twenty-four hours per day, seven days per week. Recipients may receive services in a Supportive Crisis Stabilization Center for up to twenty-four hours. SCSC is a jointly licensed program by OMH and OASAS under Title 14 NYCRR Part 600.

This program is effective 07/1/2021 for services provided in NYC, and effective 01/01/2022 for services provided in the rest of the state.

Units of Service:

- Brief Visit: A visit that is less than three hours in length.
- Full Visit: A visit that is between three hours and 24 hours in length.

1710 – Intensive Crisis Stabilization Center
(Licensed Program)

An Intensive Crisis Stabilization Center (ICSC) provides urgent treatment to children and adults experiencing a mental health and/or substance use crisis. ICSCs offer a variety of services, including rapid access to services for acute symptoms to assist in diversion from higher levels of care. ICSCs have the ability to manage and prescribe medications for mental health and/or substance use symptoms. ICSCs provide voluntary crisis treatment services with an emphasis on peer and recovery support in a safe and therapeutic environment. ICSCs will provide, or contract to provide all ICSC services on-site, behavioral health stabilization and referral services twenty-four hours per day, seven days per week. Recipients may receive services in an ICSC for up to twenty-four hours. ICSC are jointly licensed by OMH and OASAS under Title 14 NYCRR Part 600.

This program is effective 07/1/2021 for services provided in NYC, and effective 01/01/2022 for services provided in the rest of the state.

Units of Service:

- Brief Visit: A visit that is less than three hours in length.
- Full Visit: A visit that is between three hours and 24 hours in length.

1720 – 988 Crisis Hotline Center
(Non-Licensed Program)

988 Crisis Hotline Centers are NYS designated contact centers affiliated with the National Suicide Prevention Lifeline. Individuals experiencing a behavioral health crisis are provided telephone counseling, support, and connection to other components of the crisis response system by these Centers. Services are provided via call, chat, and text. Follow-up services are provided to all individuals who make contact with 988 and consent to follow-up services will receive additional support via call, chat, or text in the days following their initial contact with 988.

This program is effective 07/1/2021 for services provided in NYC, and effective 01/01/2022 for services provided in the rest of the state.

Units of Service: Number of Contacts

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

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

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

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

Units of Service: Count the total number of contacts.

1770 – Drop-In Center
(Non-Licensed Program)

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

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

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 childcare 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 14 NYCRR 594.

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), Supportive 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 minimize the symptoms and adverse effects of illness, maximize wellness, and promote recovery.

A clinic treatment program for adults shall provide the following services: outreach, initial assessment (including health screening), psychiatric assessment, crisis intervention, injectable psychotropic medication administration (for clinics serving adults), psychotropic medication treatment, psychotherapy services, family/collateral psychotherapy, group psychotherapy, and complex care management. The following optional services may also be provided: developmental testing, psychological testing, health physicals, health monitoring, and psychiatric consultation.

A clinic treatment program for children shall provide the following services: outreach, initial assessment (including health screening), psychiatric assessment, crisis intervention, psychotropic medication treatment, psychotherapy services, family/collateral psychotherapy, group psychotherapy, and complex care management. The following optional services may also be provided: developmental testing, psychological testing, health physicals, health monitoring, psychiatric consultation, and injectable psychotropic medication administration.

Units of Service: Service days. (Each day that an eligible individual receives a service is counted as a service day, without regard to the length of time or the number of procedures.)

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 – Children's HCBS Waiver Individualized Care Coordination

The intent of the Home and Community-Based Services (HCBS) Waiver, authorized in 1915(c) of the Social Security Act, is to maintain children with serious emotional disturbance (SED), who would otherwise be in hospital levels of care, in their homes and communities by reimbursing for non-traditional services. Individualized Care Coordination (ICC) includes services such as intake and screening, assessment of needs, service plan development, linking, advocacy, monitoring discharge planning and consultation.

Units of Service: Count each individual served during a month as one unit.

2250 – Children's HCBS Waiver Family Support

The Home and Community-Based Services (HCBS) Waiver, authorized in 1915(c) of the Social Security Act, is to maintain children with serious emotional disturbance (SED), who would otherwise be in hospital levels of care, in their homes and communities by reimbursing for non-traditional services. Family Support provides 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: Count each 15 minute billable unit as one unit.

2260 – Children's HCBS Waiver Crisis Response

The Home and Community-Based Services (HCBS) Waiver, authorized in 1915(c) of the Social Security Act, is to maintain children with serious emotional disturbance (SED), who would otherwise be in hospital levels of care, in their homes and communities by reimbursing for non-traditional services. Crisis Response provides activities aimed at stabilizing occurrence of child/family crisis when they arise.

Units of Service: Count each billable unit as one unit.

2270 – Children's HCBS Waiver Skill Building

The intent of the Home and Community Based Services (HCBS) Waiver, authorized in 1915(c) of the Social Security Act, is to maintain children with serious emotional disturbance (SED), who would otherwise be in hospital levels of care, in their homes and communities by reimbursing for non-traditional services. Skill Building provides activities designed to assist the child in acquiring, developing and accessing functional skills and support-both social and environmental-needed to function more successfully in the community.

Units of Service: Count each 15 minute billable unit as one unit.

2280 – Children's HCBS Waiver Intensive In-Home

The intent of the Home and Community-Based Services (HCBS) Waiver, authorized in 1915(c) of the Social Security Act, is to maintain children with serious emotional disturbance (SED), who would otherwise be in hospital levels of care, in their homes and communities by reimbursing for non-traditional services. Intensive In-Home provides ongoing activities aimed at providing intensive interventions in the home when a crisis response service is not enough.

Units of Service: Count each billable unit as one unit.

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)

An ABI is a self-sustaining business or cooperative that is owned and operated by an OMH provider (such as a small retail or wholesale outlet, or manufacturing and service-oriented business). An ABI provides integrated, competitive, employment opportunities for individuals with serious mental illness along with mental health supports onsite.

These businesses provide integrated, competitive, employment opportunities for individuals with serious mental illness. The OMH funding is for the mental health supports* needed for the person to be successful at the job. *Supports may include assisting someone in interpreting and responding appropriately to interpersonal situations at work or learning to cope with mental health symptoms to enhance their work performance. Financial/Benefits Counseling may be provided.

Care should be taken to ensure policies exist to separate the provision of mental health support from work supervision.

Note: An agency that operates a Personalized Recovery Oriented Services program (PROS) is not eligible to operate an Affirmative Business/Industry (ABI). A PROS cannot bill for employment services for individuals enrolled in an ABI.

The goal of supported employment is for individuals to work a minimum of 10 hours per week in an integrated, competitive job, with leeway for absence due to illness, vacation, or temporary work stoppages. See Glossary for definitions of “Competitive Employment” and “Integrated Employment”. To be considered employed part time, participants should be scheduled to work a minimum of 10 hours each week.

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

2370 – Children’s HCBS Waiver Youth Peer Advocate

The intent of the Home and Community-Based Services (HCBS) Waiver, authorized in 1915(c) of the Social Security Act, is to maintain children with serious emotional disturbance (SED), who would otherwise be in hospital levels of care, in their homes and communities by reimbursing for non-traditional services. Youth Peer Advocate (YPA) services offer positive youth development-centered services for waiver participants with a resiliency/recovery focus. Waiver YPA services are designed to support Waiver participants in the restoration and expansion of the skills and strategies necessary to move forward in meeting their personal, individualized life goals and to support their transitioning into adulthood. Waiver YPA services are planned to assist waiver participants with identifying and enhancing their strengths, supports (community and natural) and teach self-advocacy skills.

Units of Service: Count each 15-minute billable unit as one unit.

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.

2620 – Health Home Non-Medicaid Care Management
(Non-Licensed Program)

This program code applies to former Targeted Case Management programs, for both adults and children, that converted to Health Home Care Management (HHCM). These funds are available to the HHCM provider who in addition to serving adult Medicaid enrolled recipients with a Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED) also serves adult non-Medicaid SMI clients and non-Medicaid SED clients who cannot be enrolled in a Health Home. These funds typically support the higher acuity non-Medicaid recipients by advocating for needed services, helping to find their way through complex health care and social services systems, providing support for improved community service linkages, performing on-site crisis intervention and skills teaching when other services are not available, and if the recipient is eligible, working to secure Medicaid benefits with the goal of subsequent Health Home enrollment.

Units of Service: Report year end sum of the total persons served per month.

2680 – Crisis Intervention
(Non-Licensed Program)

Crisis intervention services, applicable to adults, children and adolescents, are intended to stabilize behavioral health symptoms and return individuals to pre-crisis levels of functioning and build and strengthen natural supports to maximize community tenure. Programs that exclusively provide phone support, such as warm lines or hot lines should be coded under Advocacy/Support Services 1760.

This program should not be used for NYS approved mobile crisis teams when providing services described under Mobile Crisis (0680) or CPEP crisis outreach (1680) or CFTSS Crisis Intervention (4910) or crisis services provided by licensed out-patient programs.

Units of Service: Count the total staff hours.

2720 – Non-Medicaid Care Coordination
(Non-Licensed Program)

This program supports people with serious mental illness (SMI) and/or children with serious emotional disturbance (SED), regardless of Medicaid enrollment. Care coordination services may include linking people to needed services, monitoring established goals and outcomes and providing case specific advocacy. The program does not bill Medicaid for its services. Funding is provided via State Aid. People who meet Health Home eligibility should not be served with these resources; they should be enrolled in a Health Home Care Management program.

This program code includes the former Bridger Services (previously program code 1990) and Case Management Services (previously program code 0810).

Units of Service: Staff Hours (Count the total number of staff hours spent providing care coordination face-to-face or by telephone directly to recipients or collaterals).

2730 – Health Home Care Management
(Non-Licensed Program)

Health Home Care Managers provide comprehensive, integrated medical and behavioral health care management to Medicaid-enrolled individuals with chronic conditions to ensure access to appropriate services, improve health outcomes, and prevent avoidable hospitalizations and emergency room visits. Health Home Care Management (HHCM) services include health promotion; transitional care, including follow-up from inpatient to other settings; patient and family support; and referral to community and social support services.

Agencies who are also Specialty Mental Health Care Management agencies should report under the Specialty Mental Health Care Management code (0780) and not report under 2730 program code, effective 1/1/22 (Upstate) and 7/1/22 (NYC).

Units of Service: Report year end sum of the total persons served per month.

2740 – Health Home Care Management Service Dollars
(Non-Licensed Program)

The Health Home Care Management Service Dollars program code will track service dollars of former Targeted Case Management (TCM) programs that subsequently converted into Health Home Care Management under the Health Home entity.

Service dollars may only be used for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) receiving care management services and are assigned to a former Intensive, Blended or Supportive Case Management Legacy Provider; Children's Waiver ICC agencies that are also TCM legacy providers and for non-Medicaid eligible individuals assigned via the LGU/SPOA process. Service dollars may not be used for any other individual who is served by the care management program.

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 recipient of services should play a significant role in decisions regarding the utilization of service dollars. As the needs of the recipient change, the money can be redirected to purchase the type of service that is currently needed.

Please reference the Flexible Recipient Service Dollar Spending Plan guidelines for acceptable use of service dollars. Use of service must be reflected in the recipient's plan of care or service record.

Units of Service: Count the number of recipients utilizing these funds.

2750 – Recovery Center
(Non-Licensed Program)

A program of peer support activities that are designed to help individuals with psychiatric diagnosis live, work and fully participate in communities. These activities are based on the principle that people who share a common condition or experience can be of substantial assistance to each other. Specific program activities will: build on existing best practices in self-help/peer support/mutual support; incorporate the principles of Olmstead; assist individuals in identifying, remembering or discovering their own passions in life; serve as a clearinghouse of community participation opportunities; and then support individuals in linking to those community groups, organizations, networks or places that will nurture and feed an individual's passions in life. Social recreation events with a focus on community participation opportunities will be the basis for exposing individuals to potential passion areas through dynamic experiences, not lectures or presentations. This program will be funded through performance-based contracts with a specified set of deliverables.

Units of Service: Measured by staff hours.

2770 – Self Help Program
(Non-Licensed Program)

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

- 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.

2850 – Health Home Care Management Service Dollar Administration
(Non-Licensed Program)

The Health Home Care Management Service Dollar Administration program is used to report administration or Representative Payee Service costs for the Health Home Care Management Service Dollar Program for former OMH Targeted Case Management (TCM) programs that subsequently converted into Health Home Care Management under the Health Home entity. Costs should not exceed 10% of total Health Home Care Management Service dollars spent, up to the maximum of 10% of the total allocation.

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.

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 Service Dollars
(Non-Licensed Program)

RTF Transition Coordinators 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 this program 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.

This program may also be associated with the funding of specific recruitment and retention funding awards. Recruitment and retention activities associated with a specific award and the duration of the award will be considered under this program. Workforce recruitment and retention activities include, but are not limited to recruitment and retention incentives, bonuses, educational opportunities, and career development training for RTF staff.

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.

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)

OMH will not support any new programs in this category; existing programs may continue.

Work Programs provide individuals (ages 18+) with serious mental illness with vocational assessment and job skills training, followed by transitional work experience at competitive wages. Employees typically work in a small, single purpose service business often organized as a not-for-profit. Typically, this model has eight or fewer employees under the direct supervision of a job coach provided by the vocational rehabilitation provider and they perform such services as cleaning or landscaping, etc.

Opportunities for integration are provided through interaction with customers and the general public while individuals perform their work. Employees must make at least minimum wage or higher.

The OMH "Work Program" model is sometimes referred to as "mobile crews" or "mobile work crews".

*See Glossary for definitions of "Competitive Employment" and "Integrated Employment".

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.

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

These services are allocated for specific individuals who have achieved job stabilization though ACCES-VR intensive employment services and are designed to provide ongoing supports to overcome mental health challenges in order to sustain integrated, competitive employment, or support for promotion or to find new employment.

Note: In a county where a Personalized Recovery Oriented Services program (PROS) is located, no OISE slots may be backfilled when an individual leaves OISE; ongoing supports should instead be offered via the ORS component of PROS.

The goal of supported employment is for individuals to work a minimum of 10 hours per week in an integrated, competitive job, with leeway for absence due to illness, vacation, or temporary work stoppages. See Glossary for definitions of "Competitive Employment" and "Integrated Employment". To be considered employed part time, participants should be scheduled to work a minimum of 10 hours each week.

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

4610 – Adult Behavioral Health Home and Community Based Services (BH HCBS) Ongoing Supported Employment (OSE) (Non-Licensed Program)

This service is provided after a participant successfully obtains and becomes oriented to competitive and integrated employment. Ongoing follow-along is support available for an indefinite period as needed by the participant to maintain their paid employment position. Individual employment support services are individualized, person centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

Units of Service: 15 Minutes.

4620 – Adult Behavioral Health Home and Community Based Services (BH HCBS) Intensive Supported Employment (ISE) (Non-Licensed Program)

ISE services assist individuals with individuals with mental health (MH) or substance use disorders (SUD) to obtain and keep competitive employment. These services consist of intensive supports that enable individuals to obtain and keep competitive employment at or above the minimum wage. This service will follow the evidence-based principles of the Individual Placement and Support (IPS) model. This service is based on IPS model which is an evidence-based practice of supported employment. It consists of intensive supports that enable individuals for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their clinical and functional needs, require supports to perform in a regular work setting. Individual employment support services are individualized, person-centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support. Services that consist of intensive supports that enable participants for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their disabilities, need supports to perform in a regular work setting.

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

Units of Service: 15 Minutes.

4630 – Adult Behavioral Health Home and Community Based Services (BH HCBS) Transitional Employment (Non-Licensed Program)

This service is designed to strengthen the participant'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. This service is provided, instead of individual supported employment, only when the person specifically chooses this service and may only be provided by clubhouse, psychosocial club program certified provider or recovery center. This service specifically provides learning and work experiences where the individual with behavioral health and/or substance use disorders can develop general, non-job-task-specific strengths and soft skills that contribute to employability in the competitive work environment in integrated community settings paying at or above minimum wage. The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

Unit of Service: 15 Minutes.

4640 – Adult Behavioral Health Home and Community Based Services (BH HCBS) Pre-Vocational Services (Non-Licensed Program)

Pre-vocational services are time-limited services that prepare a participant for paid or unpaid employment. This service specifically provides learning and work experiences where the individual with mental health and/or disabling substance use disorders can develop general, non-job-task specific strengths and soft skills that that contribute to employability in competitive work environment as well as in the integrated community settings. Pre-vocational services occur over a defined period of time and with specific person-centered goals to be developed and achieved, as determined by the individual and his/her employment specialist and support team and ongoing person-centered planning process as identified in the individual's person-centered plan of care. Pre-vocational services provide supports to individuals who need ongoing support to learn a new job and/or maintain a job in a competitive work environment or a self-employment arrangement. The outcome of this pre-vocational activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

Units of Service: Direct Care/Service Hours

4650 – CORE Empowerment Services - Peer Supports (Non-Licensed Program)

Empowerment Services (Peer Support) are non-clinical, peer-delivered services with focus on rehabilitation, recovery, and resilience. They are designed to promote skills for coping with and managing behavioral health symptoms while facilitating the utilization of natural supports and community resources.

Peer support must include the identified goals or objectives in the member's individualized service plan, with interventions tailored to the individual. These goals should promote utilization of natural supports and community services, supporting the person's recovery and enhancing the quality of their personal and family life. The intentional, goal-directed activities provided by this service emphasize the opportunity for peers to model skills and strategies necessary for recovery, thereby developing the individual's skills and self-efficacy. These services are provided through the perspective of a shared personal experience of recovery, enhancing the individual's sense of empowerment and hope.

CORE services are only available to individuals in a HARP or HIV SNP, and who have been recommended for CORE services by a Licensed Practitioner of the Healing Arts (LPHA).

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

Units of Service: 15 Minutes.

4660 – Adult Behavioral Health Home and Community Based Services (BH HCBS) Education Support Services (ESS) (Non-Licensed Program)

Education Support Services are provided to assist individuals with mental health or substance use disorders who want to start or return to school or formal training with a goal of achieving skills necessary to obtain employment. Education Support Services consist of special education and related services as defined in Sections (22) and (25) of the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) (20 U.S.C. 1401 et seq.), to the extent to which they are not available under a program funded by IDEA or available for funding by the NYS Adult Career and Continuing Education Services Office of Vocational Rehabilitation (ACCES-VR) (The Vocational Rehabilitation component (ACCES-VR) encompasses many of the services that were previously part of Vocational and Educational Services for Individuals with Disabilities, or VESID).

Education Support Services may consist of general adult educational services such as applying for and attending community college, university or other college-level courses. Services may also include classes, vocational training, and tutoring to receive a Test Assessing Secondary Completion (TASC) diploma, as well as support to the participant to participate in an apprenticeship program.

Participants authorized for Education Support Services must relate to an employment goal or skill development documented in the service plan. Education Support Services must be specified in the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. Examples of these goals would include, but not be limited to: tutoring or formal classes to obtain a Test Assessing Secondary Completion (TASC) diploma, vocational training, apprenticeship program or formal classes to improve skills or knowledge in a chosen career, community college, university or any college-level courses or classes.

Ongoing Supported Education: is conducted after a participant is successfully admitted to an educational program. Ongoing follow-along is support available for an indefinite period as needed by the participant to maintain their status as a registered student.

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

Units of Service: Direct Care/Service Hours.

4670 – Adult Behavioral Health Home and Community Based Services (BH HCBS) Intensive Crisis Respite (ICR) (Non-Licensed Program)

Intensive Crisis Respite (ICR) is a short-term, residential care and clinical intervention strategy for individuals who are facing a behavioral health crisis, including individuals who are suicidal, express homicidal ideation, or have a mental health or co-occurring diagnosis and are experiencing acute escalation of mental health symptoms. In addition, the person must be able to contract for safety.

Individuals in need of ICR are at imminent risk for loss of functional abilities and may raise safety concerns for themselves and others without this level of care. The immediate goal of ICR is to provide supports to help the individual stabilize and return to previous level of functioning or as a step-down from inpatient hospitalization.

BH HCBS services are only available to individuals enrolled in a HARP or HIV SNP, who have been approved for HCBS services in their plan of care.

- Individuals must have an acute medical condition requiring higher level of care.
- 7 days maximum per episode.
- Intensive Crisis Respite services include a limit of 21 days per year. Individuals requiring Intensive Crisis Respite for longer periods than those specified may be evaluated on an individual basis and approved for greater length of stay based on medical necessity.

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

Units of Service: Resident Days.

4680 – Adult Behavioral Health Home and Community Based Services (BH HCBS) Short-Term Crisis Respite (Non-Licensed Program)

Short-term Crisis Respite is a short-term care and intervention strategy for individuals who have a mental health or co-occurring diagnosis and are experiencing challenges in daily life that create risk for an escalation of symptoms that cannot be managed in the person's home and community environment without onsite supports including:

- A mental health or co-occurring diagnosis and are experiencing challenges in daily life that create imminent risk for an escalation of symptoms and/or a loss of adult role functioning but who do not pose an imminent risk to the safety of themselves or others.

- A challenging emotional crisis occurs which the individual is unable to manage without intensive assistance and support.

- When there is an indication that a person's symptoms are beginning to escalate.

Referrals to Crisis Respite may come from the emergency room, the community, self-referrals, a treatment team, or as part of a step-down plan from an inpatient setting. Crisis respite is provided in site-based residential settings. Crisis Respite is not intended as a substitute for permanent housing arrangements.

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

Units of Service: Resident Days.

4690 – CORE Family Support and Training (FST) (Non-Licensed Program)

Family Support and Training offers instruction, emotional support, and skill building necessary to facilitate engagement and active participation of the family in the individual's recovery process. The FST practitioner partners with families through a person-centered or person-directed, recovery oriented, trauma-informed approach.

Family is defined as the individual's family of choice. This may include persons who live with or provide support to a person, such as a parent, spouse, significant other, children, relatives, foster family, or in-laws. Family does not include individuals who are employed to care for the participant.

CORE services are only available to individuals enrolled in a HARP or HIV SNP, and who have been recommended for CORE services by a Licensed Practitioner of the Healing Arts (LPHA).

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

Units of Service: 15 Minutes.

4700 – Adult Behavioral Health Home and Community Based Services (BH HCBS) Habilitation (Non-Licensed Program)

Habilitation services are typically provided on a 1:1 basis and are designed to assist participants with a behavioral health diagnosis (i.e. substance use disorder (SUD) or mental health) in acquiring, retaining and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources and adaptive skills necessary to reside successfully in home and community-based settings. These services assist participants with developing skills necessary for community living and, if applicable, to continue the process of recovery from a SUD disorder. Services include things such as: instruction in accessing transportation, shopping and performing other necessary activities of community and civic life including self-advocacy, locating housing, working with landlords and roommates and budgeting. Services are designed to enable the participant to integrate full into the community and endure recovery, health, welfare, safety and maximum independence of the participant.

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

Units of Service: 15 Minutes.

4710 – CORE Psychosocial Rehabilitation (PSR) (Non-Licensed Program)

Psychosocial Rehabilitation (PSR) is designed to assist an individual in improving their functional abilities to the greatest degree possible in settings where they live, work, learn, and socialize. Rehabilitation counseling, skill building, and psychoeducational interventions provided through PSR are used to support attainment of person-centered recovery goals and valued life roles. Approaches are intended to develop skills to overcome barriers caused by a participant's behavioral health disorder and promote independence and full community participation. CORE PSR will incorporate allowable service components of Adult BH HCBS education, vocational, and habilitation services.

CORE services are only available to individuals enrolled in a HARP or HIV SNP, and who have been recommended for CORE services by a Licensed Practitioner of the Healing Arts (LPHA).

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

Units of Service: 15 Minutes.

4720 – CORE Community Psychiatric Support and Treatment (CPST) (Non-Licensed Program)

CPST includes time-limited, goal-directed supports and solution-focused interventions with the intent to achieve person-centered goals and objectives. This is a multi-component service that consists of therapeutic interventions such as clinical counseling and therapy, which assist the consumer in achieving stability and functional improvement in the following areas: daily living, finances, housing, education, employment, personal recovery and/or resilience, family and interpersonal relationships and community participation. CPST is designed to provide mobile treatment services to individuals who have difficulty engaging in site-based programs, or who have not been previously engaged in services, including those who had only partially benefited from traditional treatment. CPST allows for delivery of services within a variety of permissible off-site settings including, but not limited to, community locations where the individual lives, works, learns, and/or socializes.

CORE services are only available to individuals enrolled in a HARP or HIV SNP, and who have been recommended for CORE services by a Licensed Practitioner of the Healing Arts.

This program is effective 01/01/2016 for services provided in NYC, and effective 10/01/2016 for services provided in the rest of the state.

Units of Service: 15 Minutes.

4740 – Adult Behavioral Health (BH) Home and Community Based (HCBS) Self-Directed Care (Non-Licensed Program)

Self-Directed Care is a Behavioral Health (BH) Home and Community Based (HCBS) service that allows individuals to work towards accomplishing recovery goals by developing and managing a self-directed care budget, pursuant to the Self-Directed Program Policy Manual. Support Brokers will work with participants to articulate recovery goals and create individualized budgets to purchase goods and services that will further these goals.

Units of Service: Staff Hours.

4800 – Children and Youth Assertive Community Treatment (Licensed Program)

The Child and Adolescent Assertive Community Treatment (ACT) team is a community-based program which provides or arranges for services, treatment and support to families with children at significant risk for out-of-home placement for whom traditionally structured services have not met their needs. The team offers a point of responsibility for serving youth with serious emotional disturbance. By providing intensive home and community-based services in the youth's home community, the team can preserve family integrity and prevent unnecessary out-of-home placement. Teams employ a wraparound, strength-based care coordination model which is child-centered and family-focused, fundamental to enhancing resiliency, meeting the imperatives of developmental stages and promoting wellness for each child and family. It ensures effective interventions by implementing a creative and collaborative partnership with the family, treatment provider(s), community-based services and other natural supports. Intensive in-home services include case management, therapy, education and skill building services, among others to improve the families and youth's skills and abilities.

Units of Service: Count the total number of contacts.

4900 – Children & Family Treatment & Support Services: Family Peer Support Services (FPSS)

As a Medicaid funded Children's Health and Behavioral Health Services program, FPSS are an array of formal and informal activities and supports provided to families caring for/raising a child who is experiencing social, emotional, medical, developmental, substance use and/or behavior challenges in his/her life. FPSS provide a structured, strength-based relationship between a Family Peer Advocate (FPA) and the parent/family member/caregiver for the benefit of the child/youth. The need for this service must be determined by a licensed practitioner and included within a treatment plan. Family is defined as the primary care-giving unit and is inclusive of the wide diversity of primary caregiving units in our culture. Service components include activities to help the families to develop resources and supports for the benefit of the child/youth, including engagement, bridging and transition, self-advocacy, self-efficacy and empowerment, parent skill development, and community connections. Please reference the Medicaid State Plan Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Testing (EPSDT) Services for definitions of service components and staffing requirements.

This program is effective 07/01/2018 for services provided in NYC, and effective 01/01/2019 for services provided in the rest of the state.

Units of Service: Count the number of visits.

4910 – Children & Family Treatment & Support Services: Mobile Crisis Intervention (CI)

As a Medicaid funded Children's Health and Behavioral Health Services program, CI services are mobile services provided to children/youth under age 21 who are identified as experiencing acute psychological/emotional change which results in a marked increase in personal distress, and which exceeds the abilities and resources involved to resolve it effectively. CI is a face-to-face intervention that can occur in a variety of settings. CI services are available 24 hours per day, seven days per week and respond within 1 hour of the completion of the initial call to the crisis provider, and upon determination that an in-person contact is required. Services are provided through a multi-disciplinary team to enhance engagement and meet the unique needs of the child/youth and family. The team must be comprised of at least two professionals and one of these two must be a licensed behavioral health professional with crisis intervention service delivery experience. Please reference the Medicaid State Plan Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Testing (EPSDT) Services for specific service components and staffing requirements.

This program is effective 07/01/2018 for services provided in NYC, and effective 01/01/2019 for services provided in the rest of the state.

Units of Service: Count the number of visits.

4920 – Children & Family Treatment & Support Services: Youth Peer Support (YPS)

As one of the six Medicaid Funded Children's Health and Behavioral Health Services, YPS services are formal and informal services designed to support youth who are experiencing social, medical, emotional, developmental, substance use, and/or behavioral challenges in their home or community. The service provides the support necessary to encourage engagement and active participation of the youth in the treatment planning process and with the ongoing implementation and reinforcement of skills. The service is delivered by a Credentialed Youth Peer Advocate (CYPA), who must be 18 to 30 years old and has self-identified as a person who has first-hand experience with social, emotional, medical, developmental, substance use, and/or behavioral challenges. The need for this service must be determined by a licensed practitioner and included within a treatment plan. Service components include activities to help the youths to achieve functional improvement, including skill building, coaching, engagement, bridging and transition support, self-advocacy, self-efficacy and empowerment, and community connections and natural support. Please reference the Medicaid State Plan Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Testing (EPSDT) Services for definitions of service components and state requirements.

This program is effective 07/01/2018 for services provided in NYC, and effective 01/01/2019 for services provided in the rest of the state.

Units of Service: Count the number of visits.

4930 – Children & Family Treatment & Support Services: Psychosocial Rehabilitation (PSR)

As a Medicaid funded Children's Health and Behavioral Health Services program, PSR services are designed to restore, rehabilitate, and support a child's/youth's developmentally appropriate functioning as necessary for the integration of the child/youth as an active and productive member of his/her family and community with the goal of achieving minimal on-going professional intervention. Activities are "hands on" and task oriented, intended to achieve the identified goals or objectives as set forth in the child/youth's individualized treatment plan. Service components include skill development to support personal and community competence, including social and interpersonal skills, daily living skills, and community integration. Please reference the Medicaid State Plan Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Testing (EPSDT) Services for definitions of service components and staffing requirements.

PSR services are to be recommended by a licensed practitioner and as part of a treatment plan. PSR activities are focused on addressing the rehabilitative needs of the child/youth as part of a treatment plan and can be provided in coordination with treatment interventions by a licensed practitioner (e.g., OLP) or provider of community psychiatric support and treatment (CPST).

This program is effective 07/01/2018 for services provided in NYC, and effective 01/01/2019 for services provided in the rest of the state.

Units of Service: Count the number of visits.

4940 – Children & Family Treatment & Support Services: Other Licensed Practitioner (OLP)

As a Medicaid funded Children's Health and Behavioral Health Services program, OLP consists of three different service components: evaluation, counseling, and crisis. Service components include licensed evaluation (assessment); psychotherapy (counseling); and crisis intervention. OLP is performed by an individual who is licensed in NYS to diagnose, and/or treat individuals with a physical illness, mental illness, substance use disorder, or functional limitations at issue, operating within the scope of practice defined in NYS law and in any setting permissible under State law. OLP services can be provided to individuals, families, or groups, and can be provided on-site or off-site. Please reference the Medicaid State Plan Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Testing (EPSDT) Services for definitions of service components and staffing requirements.

This program is effective 07/01/2018 for services provided in NYC, and effective 01/01/2019 for services provided in the rest of the state.

Units of Service: Count the number of visits.

4950 – Children & Family Treatment & Support Services: Community Psychiatric Support and Treatment (CPST)

As a Medicaid funded Children's Health and Behavioral Health Services program, CPST services are goal-oriented supports and solution-focused interventions intended to address challenges associated with a behavioral health need and to achieve identified goals or objectives from the child's treatment plan. CPST is a face-to-face intervention with the child/youth (required), family/caregiver or other collateral supports. Service components include intensive interventions, crisis avoidance and management, rehabilitative psychoeducation, strengths-based service planning and rehabilitative supports. Please reference the Medicaid State Plan Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Testing (EPSDT) Services for definitions of service components and staffing requirements.

This program is effective 07/01/2018 for services provided in NYC, and effective 01/01/2019 for services provided in the rest of the state.

Units of Service: Count the number of visits.

5010 – OnTrackNY Coordinated Specialty Care First Episode Psychosis Program (Non-Licensed Program)

OnTrackNY is a team-based, intensive, evidence-based and recovery-oriented Coordinated Specialty Care (CSC) program. It serves youth and young adults ages 16-30 experiencing newly emergent non-affective psychotic disorders. OnTrackNY helps youth to achieve their goals for school, work, and social relationships, avoid disability, and reduce hospitalization rates. Principles of care include shared decision making, flexible and accessible services to individuals meeting clinical admission criteria. The OnTrackNY CSC team provides on-and off-site services including outreach, screening and referral, initial and ongoing psychiatric assessments, pharmacotherapy, integrated substance use treatment, individual and group psychotherapy services, family/collateral psychotherapy and support, crisis intervention, complex care management, primary care coordination, health monitoring, case management, supported employment and education, and peer support.

This program is effective 01/01/20 for Calendar year filers and 07/01/20 for Fiscal year filers.

Units of Service: Service days. (Each day that an eligible individual receives a service is counted as a service day, without regard to the length of time or the number of procedures.)

5020 – Intensive Crisis Residence (Licensed Program)

An Intensive Crisis Residence Program means a short-term, residential and treatment program, up to 28 days for individuals who are experiencing a psychiatric crisis, which includes acute escalation of mental health symptoms and do not pose likelihood of serious harm. This service is available to individuals 18 years and older. This program must be licensed under Part 589.

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

5030 – Residential Crisis Support
(Licensed Program)

A Residential Crisis Support Program means a short-term residential program up to 28 days for treatment and support to individuals who are experiencing symptoms of mental illness, psychiatric crisis or are experiencing challenges in daily life that create risk for an escalation of psychiatric symptoms that cannot reasonably be managed in the person's home and/or community environment without onsite supports and do not pose likelihood of serious harm. This program is available for individuals 18 years and older. The program must be licensed under Part 589.

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

5070 – Supportive 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.

6060 – Supportive Housing
(Non-Licensed Program)

This includes all services provided to residents of supportive housing programs by the supportive housing agency. 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.

Rental assistance is provided to residents of supportive 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.

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 14 NYCRR 595.

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.

6140 – Transformed Business Model
(Non-Licensed Program)

A Transformed Business Model was designed to transform those employment opportunities offered by a sheltered workshop provider into competitive, integrated jobs. This model may only be funded in an agency that formerly operated a sheltered workshop program and/or currently provides services through a Personalized Recovery Oriented Services program (PROS).

A Transformed Business Model is a self-sustaining business such as a small retail or wholesale outlet, or manufacturing and service-oriented business that is owned and operated by an OMH provider; a TBM provides both employment and mental health supports onsite.

These businesses provide integrated, competitive, employment opportunities for individuals with serious mental illness. The OMH funding is for the mental health supports* needed for the person to be successful at the job. *Supports may include assisting someone in interpreting and responding appropriately to interpersonal situations at work or learning to cope with mental health symptoms to enhance their work performance. Financial/Benefits Counseling may be provided.

Care should be taken to ensure policies exist to separate the provision of mental health support from work supervision.

Note: A PROS program cannot bill for employment services for individuals employed in a TBM.

The goal of supported employment is for individuals to work a minimum of 10 hours per week in an integrated, competitive job, with leeway for absence due to illness, vacation, or temporary work stoppages. See Glossary for definitions of “Competitive Employment” and “Integrated Employment”. To be considered employed part time, participants should be scheduled to work a minimum of 10 hours each week.

Units of Service: Unique number of individuals served per year.

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: Report the sum of the total monthly units of service for the year, as calculated using the PROS Unit Conversion Chart, which can be found in the PROS Finance Handbook located at www.omh.ny.gov.

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.

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 14 NYCRR 594.

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 14 NYCRR 595.

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 14 NYCRR 595.

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: Report the sum of the total monthly units of service for the year, as calculated using the PROS Unit Conversion Chart, which can be found in the PROS Finance Handbook located at www.omh.ny.gov.

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 14 NYCRR 595.

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

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. The populations served are adults and children/adolescents.

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 OPWDD 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 Supports	0221
Assistive Technology Administration (Pilot)	0256
Case Management (Non-Medicaid)	0810
CCO – Medicaid Basic HCBS Plan Support	0501
CCO – Medicaid Health Home Care Management (Tier I, Tier II, Tier III and Tier IV)	0500
CCO – Non-Medicaid Care Management (Willowbrook, State Paid Care Management, Early Intervention)	0502
Certified Work Activity/Sheltered Workshop	0340
Classroom Education	0360
Community Based Vocational Services for Individuals Residing in an Intermediate Care Facility	0095
Consumer Transportation	0670
Crisis Intervention	0060
Crisis Services for Individuals with Developmental Disabilities (CSIDD)	0066
Day Services for Individuals Residing in an Intermediate Care Facility	0092
Day Training	0330
Day Treatment – Freestanding	0200
Day Treatment – Partial	0202
Developmental Disabilities Program Council Grant	2190
Empire State Supportive Housing Initiative (ESSHI)	0056
Epilepsy Services	0414
Family Support Services	0150
HCBS Assistive Technologies - Adaptive Devices	0216
HCBS Camp Respite	0314
HCBS Community Based Prevocational Services	0203
HCBS Community Transition Services	0241
HCBS Community Habilitation - Residential Service	0257
HCBS Environmental Modifications	0215
HCBS Family Education and Training	0413
HCBS Fiscal Intermediary Service	0421
HCBS Group Day Habilitation Service (Certified Site)	0204
HCBS Group Day Habilitation Service (Without Walls)	0205
HCBS Hourly Community Habilitation Service	0237
HCBS Individual-Directed Goods and Services	0425
HCBS In-Home Respite	0311
HCBS Intensive Behavioral Services	0260
HCBS Intensive Respite	0313
HCBS Live-in Caregiver	0415
HCBS Pathway to Employment	0209
HCBS Site Based Prevocational Services	0227
HCBS Recreational Respite	0315
HCBS Residential Habilitation Family Care	0220
HCBS Self-Hired Community Habilitation	0422
HCBS Self-Hired Respite Service	0423
HCBS Self-Hired Supported Employment	0424
HCBS Site Based Respite	0312
HCBS Supervised IRA (Room and Board and Residential Habilitation Services)	0231
HCBS Support Broker Services	0426
HCBS Supported Employment	0214
HCBS Supportive IRA (Room and Board and Residential Habilitation Services)	0232
HCBS Vehicle Modifications	0246
Home Care	0630
ICF/IID (Over 30 Beds)	1090

Program Name	Program Code
ICF/IID (30 Beds or Less)	0090
Individualized Support Services	0410
Information and Referral	0750
In-Home Services for Individuals Residing in an Intermediate Care Facility	0093
Integrated Community Program	0242
Local Governmental Unit (LGU) Administration	0890
OPWDD Part 679 Clinic Treatment Facility (Article 16 Clinic)	0100
OPWDD Part 680 Specialty Hospital	0121
Preschool Program	0370
Program Development Grants and Start-Up	0190
Recreation and/or Fitness	0610
Residential Reserve for Replacement (RRR) – Freestanding Respite	0294
Residential Reserve for Replacement (RRR) – Supervised IRA	0297
Residential Reserve for Replacement (RRR) – Supportive IRA	0298
Self-Directed Housing Subsidies	0428
Self-Directed OTPS/Family Reimbursed Respite	0427
Senior Companion	0306
SOICF Sheltered Workshop/Day Training	4090
Special Legislative Grant	1190
START Services	0065
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
Transformation Opportunities	0300
Transitional Employment	0380
Traumatic Brain Injury (TBI)	1150
Site Based Vocational Services for Individuals Residing in an Intermediate Care Facility	0094
Voluntary Preservation Project – Formerly Known as Voluntary Operated Maintenance Project (aka VAMM)	1850

0056 - Empire State Supportive Housing Initiative (ESSHI)

The ESSHI Initiative is an interagency initiative to provide units of supportive housing for persons identified as homeless with special needs, conditions or other life challenges. The rental subsidies and/or services provided under this initiative are intended to be a means to provide affordable and stable housing and services to families, individuals and youth/young adults who are homeless and have at least one or more disabling conditions or other life challenges.

Critical components of any project funded under this plan include the availability of and access to various support services such as employment and training opportunities, parenting education, counseling, independent living skills training, primary healthcare, substance use disorder treatment and mental health care, childcare, and benefits advocacy care.

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, increase the number of the last digit by one.

Units of Service: As per contract.

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, increase the number of the last digit by one.

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

0065 – START Services

START services provide a linkage model to promote a system of care in the provision of community services, natural supports and mental health treatment.

START services are designed to provide crisis intervention, crisis stabilization, and crisis prevention for individuals with intellectual and developmental disabilities and co-occurring mental health needs (IDD/MH) that are experiencing crisis regardless of whether they are at risk for placement or not.

START services are required to be delivered in adherence to the START model by providers, with different education backgrounds, who have received the specified training and meet the certification requirements of the Center for START Services.

Services provided through START may include the provision of:

- Timely in-home crisis response to the system of care in support of an individual with IDD/MH in crisis. In-home crisis services may not be delivered to individuals in Supervised IRAs/CRs and cannot be delivered at the same time as resource-centered based services.
- Short-term therapeutic resource-centered supports, clinical treatment, assessment and stabilization services that do not exceed more than 30 days within 1 year.
- Facilitating in the development and implementation of Cross-Systems Crisis Prevention and Intervention Plans.
- Support and technical assistance to partners in the community.

Program type reporting is required for this program. All revenues received and expenses incurred for this program 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 should be reported on CFR-1, Line 72a Medicaid Fee for Service.

Units of Service: Not applicable.

0066 - Crisis Services for Individuals with Intellectual and/or Developmental Disabilities (CSIDD)

CSIDD are rehabilitative short-term targeted services for individuals with intellectual and/or developmental disabilities who have significant behavioral or mental health needs. Services are delivered by multi-disciplinary teams that provide personalized and intensive, time-limited services for those age 6 and older. This high intensity service is for individuals who experience frequent hospitalizations, crisis visits, and the use of the mobile emergency services and are at risk of losing placement and/or services.

CSIDD is a short-term tertiary care service designed to help stabilize individuals within their existing care networks using specially trained behavioral support professionals to build skills and de-escalate the individual's behaviors. Once the individual is stabilized, the CSIDD team will discharge the individual from the team's caseload.

Program type reporting is required for this program. All revenues received and expenses incurred for this program 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 should be reported on CFR-1, Line 72a Medicaid Fee for Service.

Units of Service: The unit of service for CSIDD is one month. A maximum of one (1) unit of service may be billed for each month.

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, increase the number of the last digit 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 Individuals with Intellectual Disabilities (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. See Appendix FF for information on allocating program expenses.

If this program code is reported, an OPWDD-1, ICF/IID Schedule of Service, must be completed for each ICF/IID (30 Beds or Less) operated during the reporting period.

Notes:

- Add-on for ICF/IID SED Contract - When the ICF/IID rate includes an add-on component for an ICF/IID school contract, the liability associated with the add-on should be reported on CFR-1, line 68c under the ICF/IID program 0090 (See Section 13.0, line 68c, for additional details). The increase revenue for this service that was added to the ICF/IID rate should be reported as Medicaid in the ICF/IID program.

- 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/IID (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.

0092 – Day Services for Individuals Residing in an Intermediate Care Facility

Day services defined as part of the ICF/IID Active Treatment Plan that are provided to people with disabilities residing in an ICF/IID who attend a Day Habilitation Program.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. There should be no property related expenses reported in this program. Program site expenses are to be allocated based on Appendix FF; expenses should not be direct charged for this program. See Appendix FF for information on allocating program expenses between Program Code 0092 and Program Code 0204 or 0205. 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 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.

0093 – In-Home Services for Individuals Residing in an Intermediate Care Facility

Day program services for individuals residing in an ICF/IID whose comprehensive functional assessments require that such services be delivered by the ICF/IID.

Program type reporting is required for reporting the revenue and expense associated with Day Program Services provided by the ICF/IID. Day Program services expenses for all ICF/IID sites are to be aggregated and reported in a discrete column under Program Code 0093. The Program/Site Identification Number must be the same as one created for Program Code 0090 ICF/IID (30 Beds or Less) or 1090 ICF/IID (Over 30 Beds). The revenue is reported as Medicaid and the expense is reported using all applicable expense line items.

When Program Code 0093 is reported, there must be a corresponding Program Code 0090 or 1090 column reported.

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

0094 –Site Based Vocational Services for Individuals Residing in an Intermediate Care Facility

Vocational services defined as part of the ICF/IID Active Treatment Plan that are provided to people with disabilities residing in an ICF/IID that attend a Site Based Prevocational program.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. There should be no property related expenses reported in this program. Program site expenses are to be allocated based on Appendix FF; expenses should not be direct charged for this program. See Appendix FF for information on allocating program expenses between Program Code 0094 and Program Code 0227. 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 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.

0095 – Community Based Vocational Services for Individuals Residing in an Intermediate Care Facility

Vocational services defined as part of the VOICF/IID Active Treatment Plan that are provided to people with disabilities residing in a VOICF/IID that attend a Community Based Prevocational program.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. There should be no property related expenses reported in this program. Program site expenses are to be allocated based on Appendix FF; expenses should not be direct charged for this program. See Appendix FF for information on allocating program expenses between Program Code 0095 and Program Code 0203. 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 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).

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. **The provision for off-site services ended 3/31/16. Effective 4/1/16, services must be provided in a certified Article main or satellite clinic.**

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.

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.

Units 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, increase the number of the last digit by one.

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

0190 – Program Development Grants and Start-Up

The purpose of Program Development Grants and Start-Up funding is to assist service providers in commencing new residential or day programs funded by OPWDD.

Project specific reporting is required for this program. Report each project in its own column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, increase the number of the last digit by one.

Agency administrative costs allocated to this program via the Ratio Value allocation methodology are redistributed to other OPWDD programs in the CFR.

Units of Service: Not applicable.

0200 – Day Treatment Freestanding

A planned combination of diagnostic, treatment, and rehabilitative services provided to people with developmental disabilities 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.

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

Note: Do not include 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.

0203 – HCBS Community Based Prevocational Services

Any provider that operates an HCBS Community Based Prevocational Services program which provides services to individuals who reside in an Intermediate Care Facility must report the expenses related to serving those individuals under Program Code 0095-Community Based Vocational Services for Individuals Residing in an Intermediate Care Facility.

Services that are provided in an integrated setting aimed at preparing an individual for paid employment in the community, but which are not job task oriented. Services include teaching such concepts as compliance, attending to task, task completion, problem solving and safety. 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. See Appendix FF for information on allocating program expenses between Program Code 0095 and Program Code 0203. 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.

See Program Codes 0670 and 0880 for specifics on reporting expenses regarding transportation to and from HCBS Prevocational Services.

Note: Do not include HCBS Community 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: Report using billable units (i.e.: one quarter hour equals one unit of service).

0204 – HCBS Group Day Habilitation Service (Certified Site)

Note: Any provider that operates an HCBS Group Day Habilitation program which provides services to individuals who reside in an Intermediate Care Facility must report the expenses related to serving those individuals under Program Code 0092-Day Services for Individuals Residing in an Intermediate Care Facility.

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 people with disabilities. Group Day Habilitation Services are provided on weekdays and have a service start time prior to 3:00 p.m. and Supplemental Group Day Habilitation Services are provided with a start time after 3:00 p.m. and any time on weekends.

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. See Appendix FF for information on allocating program expenses between Program Code 0092 and Program Code 0204.

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

Note: Do not include 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.

0205 – HCBS Group Day Habilitation Service (Without Walls)

Note: Any provider that operates an HCBS Group Day Habilitation program which provides services to individuals who reside in an Intermediate Care Facility must report the expenses related to serving those individuals under Program Code 0092-Day Services for Individuals Residing in an Intermediate Care Facility.

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 people with disabilities. Group Day Habilitation Services are provided on weekdays and have a service start time prior to 3:00 p.m. and Supplemental Group Day Habilitation Services are provided with a start time after 3:00 p.m. and any time on weekends.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. (See Appendix FF for information on allocating program expenses between Program Code 0092 and Program Code 0205). 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.

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

Note: Do not include 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.

0209 – HCBS Pathway to Employment

A person-centered, comprehensive career/vocational employment planning and support service that provides assistance for individuals to obtain, maintain or advance competitive employment or self-employment. Allowable activities are broken out between direct service to an individual and indirect services. This service is time limited to a maximum of 12 months and 278 hours of service for each individual, unless OPWDD authorizes an extension.

Program type reporting is required for this program. All program sites expenses and revenues are aggregated and reported in one column. Pathway to Employment funds cannot be used to pay salaries or stipends to individuals receiving the service. If a provider has an internship program, any related salaries or stipends paid to an individual would be reported on Schedule CFR-2 in Column 9-"Other Programs". 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).

0214 – HCBS Supported Employment

Note: Include the expense and revenue related to Agency Supported Self-Directed Services for Supported Employment in this column.

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 quarter hour equals one unit of service.

0215 – HCBS Environmental Modifications

Environmental modifications are selected internal and external changes to a 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. The environmental modifications enable the person to function with greater independence in the home and without these modifications the person would require institutionalization. Environmental modifications are 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 Assistive Technologies - Adaptive Devices

Note: Effective August 1, 2017, use Program Code 0246-HCBS Vehicle Modifications to report all vehicle modifications.

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 – Assistive Supports

Notes: This program is not to be used to report rent subsidies or housing transition stipends funded through Individual Support Services contracts or Self-Directed Housing Subsidies. Refer to Program Code 0410 and Program Code 0428 for guidance on reporting these expenses.

Reporting Exception for Special Assistive Supports Prices: Do not include expenses and revenues for Assistive Supports prices that relate to supporting individuals that are served in an OPWDD program funded through a Medicaid rate or fee. In those situations, report the expenses and the revenue relating to the Assistive Supports price in the program in which the individual is served. (For example, if an Assistive Supports price supports the needs of an individual that resides in a Supervised IRA, report the expenses and revenue under Program Code 0231-HCBS Supervised IRA.)

Assistive supports include support staff for an individual or family requiring assistance and/or training in order to enhance the independence of the individual. Assistive supports must be included in the individual's service plan. Assistive supports may also include rent subsidies and housing transition stipends paid on behalf of people with disabilities.

Program type reporting is required for this program. All program sites expenses and revenues, **except as noted above**, are aggregated and reported in one column. Revenue is reported on CFR-1, Line 94 Other Revenue – Assistive Supports Revenue. 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.

0227 – HCBS Site Based Prevocational Services

Note: Any provider that operates an HCBS Prevocational Services program which provides services to individuals who reside in an Intermediate Care Facility must report the expenses related to serving those individuals under Program Code 0094-Site Based Vocational Services for Individuals Residing in an Intermediate Care Facility.

Services that are aimed at preparing an individual for paid employment, but which are not job task oriented. Services include teaching such concepts as compliance, attending to task, task completion, problem solving and safety. Report all similar services as one program/site.

Site specific reporting is required for this program type. Each site is reported separately in its own column. Use the Operating Certificate number as the Program/Site Identification Number. See Appendix FF for information on allocating program expenses between Program Code 0094 and Program Code 0227.

See Program Codes 0670 and 0880 for specifics on reporting expenses regarding transportation to and from HCBS Prevocational Services.

Note: Do not include 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.

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 (Supportive).

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. See Appendix FF for information on allocating program expenses.

Note: Do not include Day Treatment, HCBS Day Habilitation or HCBS Prevocational/HCBS Community Based 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.

Effective January 1, 2010, reimbursement for the Community Residence program was combined with the IRA program. Consequently, expenses, revenue and statistical data for the Community Residence Supervised program should be reported in the HCBS Supervised IRA program.

Units of Service: For each unit of service, count one participant day (Include units of service corresponding to *all* billed Therapeutic Leave days and Retainer days).

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).

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.

Effective January 1, 2010, reimbursement for the Community Residence program was combined with the IRA program. Consequently, expenses, revenue and statistical data for the Community Residence Supportive program should be reported in the HCBS Supportive IRA program.

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.

0237 – HCBS Hourly Community Habilitation Service

Note: Include the expense and revenue related to Agency Supported Self-Directed Services for Hourly Community Habilitation Service in this column.

Residential habilitation services are provided to individuals who live in their own home or family home. Effective October 1, 2014, individuals who reside in an Individualized Residential Alternative, Community Residence or family care home will be eligible for this service. 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 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. Effective January 1, 2014, providers must ensure that 95% of the revenue billed was used to support program expenses. Providers should report the amount of potentially recoverable funds as a negative prior period adjustment to revenue in the following year. 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.)

0241 – HCBS Community Transition Services

HCBS Waiver enrollees who are moving from a developmental center, ICF/IID, or any community-based, provider-operated living arrangement to a living arrangement in a private residence in the community where the person is directly responsible for his or her own living expenses are eligible to receive transitional funding for qualifying expenses which are non-recurring and are specific to the establishment of a residence. Individuals moving to certified community residential settings (such as a group home or supported apartment) are not eligible for community transition services because the residential provider is responsible for household expenses.

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. The revenue is reported on CFR-1, Line 72a (Medicaid Fee for Service).

Units of Service: Count each billable unit as one unit of service.

0242 – Integrated Community Program

A 100% State funded integrated community program providing residential, day and clinical services to individuals with developmental disabilities.

Report all expenses and revenues related to an approved contract established for the Integrated Community Program. The revenue should be reported on CFR-1, Line 94 Other Revenue as OPWDD State Paid Services, 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.

Integrated Community Program Service Types:

- 01 Integrated Residential Services
- 02 Day Services
- 03 Clinic Services

Units of Service: Report units as per Service Type. Units of Service are delineated in the contract.

0246 – HCBS Vehicle Modifications

The provision for the modification of the primary vehicle of the recipient determined necessary to enable the person to increase his or her ability to function in a community-based setting with independence and safety.

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.

0256 – HCBS Assistive Technology Administration

Note: Any individual contracts for Environmental Modifications or Assistive Technologies-Adaptive Devices the voluntary agency may enter into with the local DDRO for people with disabilities 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 DDRO that allow them to administer Environmental Modifications and Assistive Technologies-Adaptive Devices contracts with people with disabilities and families should report under this program code.

100% of the individual payments made by the voluntary agency to people with disabilities or families to reimburse them for the actual cost of environmental modifications and/or the assistive technologies covered under the contract should be aggregated and reported as OTPS-Other using the description "Assistive Technology Payments to People with Disabilities/Families." Program and/or agency administrative costs incurred by the voluntary agency to oversee the environmental modification and/or the assistive 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 Assistive Technologies-Adaptive Devices) 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.

0257 – HCBS Community Habilitation – Residential Service

Note: Include the expense and revenue related to Agency Supported Self-Directed Services for Hourly Community Habilitation-Residential Service in this column.

HCBS Community Habilitation Residential (CH-R) 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 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.

Additionally, CH-R services have been made available to provide support for Supervised IRA programs during the time of the COVID-19 Emergency. Effective March 18, 2020, affected Supervised Residential Habilitation providers are able to bill a CH-R service for the provision of services for individuals that would normally attend a Day Habilitation and/or Prevocational service outside of their agency. These resources are being provided to support 24/7 care for individuals who would normally leave the home for Day Habilitation and/or Prevocational services provided by another agency on any given day. Community Habilitation service guidelines and documentation requirements are outlined in the Community Habilitation ADM, with further flexibilities granted by Waiver Appendix K, such as tele modality and use of technology to support individuals, outlined in OPWDD's August 27, 2020 *Interim COVID-19 Guidance Regarding Community Habilitation Services (https://opwdd.ny.gov/coronavirus-guidance/covid-19-guidance-documents*

Provider participation in CH-R, during the COVID-19 Emergency, is voluntary. Supervised IRAs participating in the CH-R program bill the CH-R rate under existing rates codes and MMIS IDs. Billing is limited to the OPWDD/DOH calculated number of CH-R units for individuals who were identified as having been in a Supervised IRA and participated in another agency's Day Habilitation or Prevocational program during the benchmark period. To participate in CH-R, related to the COVID-19 Emergency, providers must have a signed program attestation prior to July 11, 2020. CH-R units are not subject to appeal. However, individuals who Agencies identified as qualifying for CH-R but who are not on the OPWDD supplied roster, could be addressed with Central Operations. Day Habilitation, Prevocational Services and Community Habilitation in a supervised residence cannot be billed to Medicaid if the residential Agency is also billing the CH-R for the individual.

Program type reporting is required for this program. All program site expenses and revenues are aggregated and reported in one column. Providers must ensure that 95 percent of the revenue billed was used to support program expenses. Providers should report the amount of potentially recoverable funds as a negative prior period adjustment to revenue in the following year. 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.)

0260 – HCBS Intensive Behavioral Services

Intensive Behavioral (IB) Services are time-limited services (6 months which will be 180 calendar days) designed for individuals who live in non-certified settings or who live in Family Care Homes and who are presenting highly challenging behaviors that put them at imminent risk for placement into a more restrictive residential setting.

Initial service involves completion of the Functional Behavioral Assessment (FBA) and development of an individualized Behavioral Support Plan (BSP) by a clinical specialist working with the individual, his family and caregivers. The BSP details specific approaches, strategies, and supports to address the behavioral issues.

To be eligible for these services, an individual must be enrolled in the OPWDD HCBS waiver. The initial part of the Service is billed as a one-time only Plan Fee. Thereafter, the unit of service for plan implementation is hourly but billable on a quarter hour basis up to a maximum of 25 hours. No more than 8 hours per day is allowed. DDRO re-authorizations may allow up to 25 or 50 additional hours of service in the subsequent 180 day period billable in quarter hours. Three years must lapse before a provider may bill for a new Plan Fee for an individual who has previously received IB Services.

Program type reporting is required for this program. All revenues received and expenses incurred for this program 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 should be reported on CFR-1 Line 72a Medicaid Fee for Service.

Units of Service: Not applicable.

0294 – Residential Reserve for Replacement (RRR) – Freestanding Respite

Report all expenses directly related to Residential Reserve for Replacement (RRR) funding for the Freestanding Respite site in this column. 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 Freestanding Respite column on the same line that the revenue is reported for that program: CFR-1, Line 72a – Medicaid Fee for Service 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 directly related to Residential Reserve for Replacement (RRR) funding for Supervised IRA programs in this column. 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 72a – Medicaid Fee for Service; Line 75 – OPWDD Residential Room and Board; 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.

Note: Effective January 1, 2010, reimbursement for the Community Residence program was combined with the IRA program. Consequently, RRR for a Community Residence Supervised program must be included with the Supervised IRA RRR using the same reporting requirements as those referenced above for the Supervised IRA.

Units of Service: Not applicable.

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

Report all expenses directly related to Residential Reserve for Replacement (RRR) funding for Supportive IRA programs in this column. 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 72a – Medicaid Fee for Service; Line 75 – OPWDD Residential Room and Board; 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.

Note: Effective January 1, 2010, reimbursement for the Community Residence program was combined with the IRA program. Consequently, RRR for a Community Residence Supportive program must be included with the Supportive IRA RRR using the same reporting requirements as those referenced above for the Supportive IRA.

Units of Service: Not applicable.

0300 – Transformation Opportunities

Through NYS's Balancing Incentives Program (BIP) Grant award, Transformation Funds provide 100% federal funding for the one-time development of plans, programs and activities supporting the goals of BIP and OPWDD's Transformation Agreement. Objectives of the program include, but are not limited to, the transition of individuals from institutional settings to home and community-based settings, increases in the numbers of individuals competitively employed, growth in the number of individuals self-directing, the identification and expansion of housing options and supporting the transition to managed care.

Proposal specific reporting is required for this program. Report each proposal in its own column. The Program/Site Identification Number is created by using the first four digits of the agency code and the last three digits of the program code. Where more than one column will be created for this program code, increase the number of the last digit by one.

Units of Service: Not applicable.

0306 – Senior Companion

A program which provides an opportunity for senior citizens to volunteer between 15-40 hours a week to support people with developmental disabilities in the following areas: community inclusion, socialization skills and activities of daily living. Senior Companions volunteer with day and residential programs and work alongside direct support professionals.

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, increase the number of the last digit by one.

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

0311 – HCBS In-Home Respite

Note: This program code is effective July 1, 2017.

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 person's family home or in another non-certified/non-licensed home (i.e., Guest Respite). In-Home respite may also include staff accompanying the individual to community (non-certified) settings.

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.)
Note: Any per diem billing should be reported as 96 units.

0312 – HCBS Site Based Respite

Note: This program code is effective July 1, 2017.

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 respite site, a certified residence, or a community setting (whether certified or not) that the provider owns, leases or pays property costs or usage fees.

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.)
Note: Any per diem billing should be reported as 96 units.

0313 – HCBS Intensive Respite

Note: This program code is effective July 1, 2017.

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 services for individuals with high behavioral and/or high medical needs that meet the qualifications for additional staffing supports due to such needs. Services can be provided in any of the defined respite settings.

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.)

0314 – HCBS Camp Respite

Note: This program code is effective July 1, 2017.

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 site-based locations that possess a permit under Subpart 7 of the NYS sanitary code.

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.)

0315 – HCBS Recreational Respite

Note: This program code is effective July 1, 2017.

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 services provided with a focus on recreational and/or community integration activities and include any programs where routine travel to an outing or event may be involved. These services are provided in locations that are not owned, rented, or leased by the provider, or not in an individual home, but may include staff accompanying the individual to non-certified community settings.

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

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

0330 – Day Training

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

Individual support services include rent subsidies and housing transition stipends paid on behalf of people with disabilities through a direct contract with OPWDD.

Note: Include transition stipends on behalf of individuals that are Self-Directing.

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, increase the number of the last digit by one.

Units of Service: As per contract.

0413 – HCBS Family Education and Training

Note: This program is not to be used to report family education and training services funded through an Assistive Supports price. Use Program Code 0221 to report family education and training services funded directly through OPWDD as State Paid Services.

HCBS Family Education and Training is training given to the families of people with disabilities 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 person with disabilities 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. The revenue is reported on CFR-1, Line 72a (Medicaid Fee for Service).

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, increase the number of the last digit 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 to the individual who is self-directing, the portion of the rent, food and utilities expense that may be reasonably attributed to the caregiver who resides in the home or residence of the individual served should be reported.

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.

0421 – HCBS Fiscal Intermediary Service

Fiscal Intermediary Services include billing and payment for self-directed services, staff hiring, assisting individual in managing staff and staff training.

Program type reporting is required for this program. All expenses paid and revenues claimed by the Fiscal Intermediary provider 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 month of service equals one unit of service.

0422 – HCBS Self-Hired Community Habilitation

Note: This program code is to be used to report Self-Hired services where the Fiscal Intermediary is the employer of record.

Residential habilitation services are provided to individuals who live in their own home, family home or who reside in an Individualized Residential Alternative, Community Residence or Family Care 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 social and adaptive skills. 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 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: Report using billable units (i.e.: one quarter hour equals one unit of service).

0423 – HCBS Self-Hired Respite Service

Note: This program code is to be used to report Self-Hired services where the Fiscal Intermediary is the employer of record.

The 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.

Program type reporting is required for this program. All program sites expenses and revenues 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: Report using billable units (i.e.: one quarter hour equals one unit of service).

0424 – HCBS Self-Hired Supported Employment

Note: This program code is to be used to report Self-Hired services where the Fiscal Intermediary is the employer of record.

Supported Employment services assist individuals 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 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: Report using billable units (i.e.: one quarter hour equals one unit of service).

0425 – HCBS Individual-Directed Goods and Services

Individual-Directed Goods and Services (IDGS) are services, equipment or supplies not otherwise provided through OPWDD's HCBS Waiver or through the Medicaid State Plan that addresses an identified need in a participant's service plan.

Program type reporting is required for this program. All program sites expenses and revenues 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: For every $10.00 spent, report one unit of service.

0426 – HCBS Support Broker Services

Support Broker Services are services which assist individuals who are self-directing with day-to-day management of self-directed services and provide support/training to individuals/families on self-directed decisions and tasks.

Program type reporting is required for this program. All program sites expenses and revenues 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: Report using billable units (i.e.: one quarter hour equals one unit of service).

0427 – Self-Directed OTPS/Family Reimbursed Respite

Report revenue and expenses for Other Than Personal Services (OTPS) and Family Reimbursed Respite services relating to self-directed budgets.

Program type reporting is required for this program. All program sites expenses and revenues 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: For every $10.00 spent, report one unit of service.

0428 – Self-Directed Housing Subsidies

Report revenue and expenses for Housing Subsidies relating to self-directed budgets.

Note: For individuals that are self-directing and receive a transition stipend, report the expense and revenue relating to the transition stipend under Program Code 0410.

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

0500 – CCO Medicaid Care Management (Tier I, Tier II, Tier III & Tier IV)

CCO/HH Care Management is a program designated/certified by the New York State Department of Health (DOH) in partnership with the Office for People with Developmental Disabilities (OPWDD) and in accordance with Section 365-l of the Social Services Law and operating under the federal Health Home program.

The Health Home Care Management model was expanded to serve individuals with I/DD through CCO/HHs, effective July 1, 2018. This is the most comprehensive Care Management option provided by CCO/HHs. The coordination of an individual's care is done through a dedicated Care Manager who oversees and coordinates access to all services.

This service is designed to provide a strong stable person-centered approach to holistic service planning and coordination required to ensure the delivery of quality care that is integrated and supports the needs of individuals with I/DD.

Program type reporting is required for this program. All revenues received and expenses incurred for this program 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: The unit of service for CCO/HH Care Management is one month. A maximum of one (1) unit of service may be billed for each month.

0501 – CCO Medicaid Basic HCBS Plan Support

Basic Home and Community Based Services (HCBS) Plan Support is a State Plan service for individuals who choose not to enroll in CCO/HH Care Management. This service coordinates and arranges for the provision of Waiver services only.

This service provides the necessary assistance to conduct timely reviews and updates to an individual's Life Plan and maintain documentation supporting the individual's HCBS Waiver Intermediate Care Facility Level of Care Eligibility Determination (ICF LCED). The service is designed to coordinate the needs of the individual as described in their Life Plan. Individuals receiving a Waiver service must have a Life Plan and this requirement can be met through enrollment into this service.

Program type reporting is required for this program. All revenues received and expenses incurred for this program 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: The unit of service for Basic HCBS Plan Support is one month. This service is billable for up to a maximum of four (4) service months per a twelve (12) month period.

0502 – CCO-Non-Medicaid Care Management (Willowbrook Case Services, Willowbrook Service Coordination, State Paid Care Management, Early Intervention)

These services may be authorized for individuals in need of Care Management services but who do not qualify for Health Home Care Management or Basic HCBS Plan Support. These individuals include:

- Willowbrook Class Members who reside in residential settings that preclude enrollment into Health Home Care Management or Basic HCBS Plan Support.
- Individuals who are not able to obtain Medicaid but require Care Management services.
- Children enrolled in Early Intervention (EI) services who are enrolled in the HCBS Waiver or are seeking services to enroll in the HCBS Waiver.

Program type reporting is required for this program. All revenues received and expenses incurred for this program 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: See chart below

Type of Non-Medicaid Care Management	Billing Frequency	Description
Willowbrook Case Services	Monthly	Willowbrook Class Members residing in an ICF/IID.
Willowbrook Service Coordination	Monthly	Willowbrook Class Members residing in a Nursing Home or other non-qualifying setting.
State Paid Care Management	Monthly	Individuals who qualify under the Liability for Services Regulations for State Paid Care Management
Early Intervention	Twice Annually	Early Intervention children enrolled in the HCBS/1115 Waiver.

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, increase the number of the last digit 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, increase the number of the last digit 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 participants. 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, increase the number of the last digit 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 person with disabilities 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 person with disabilities 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 person with disabilities' treatment plan.

Case-Specific Advocacy - Interceding on behalf of a person with disabilities 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 people with disabilities 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 person with disabilities 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, increase the number of the last digit 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 people with disabilities or collaterals.

Indirect staff hours - The number of staff hours spent by staff in providing case management services on behalf of people with disabilities other than face-to-face or by telephone directly with people with disabilities 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 Individuals with Intellectual Disabilities (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/IID Schedule of Service, must be completed.

Notes:

- Add-on for ICF/IID SED Contract - When the ICF/IID rate includes an add-on component for an ICF/IID school contract, the liability associated with the add-on should be reported on CFR-1, line 68c under the ICF/IID program 1090 (See Section 13.0, line 68c, for additional details). The increase revenue for this service that was added to the ICF/IID rate should be reported as Medicaid in the ICF/IID program.

- 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/IID (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, increase the number of the last digit by one.

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.

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 contract number, replacing the starting letter of the contract number with "0", in order to create a seven-digit number. (If no contract number is available, use the first four digits of the agency code and the last three digits of the program code).

Units of Service: Not applicable.

4090 – State Operated Intermediate Care Facility for Individuals with Intellectual Disabilities, Sheltered Workshop/Day Training

Sheltered Workshop/Day training services defined as part of the SOICF/IID Active Treatment Plan that are provided to SOICF/IID people with disabilities via a contract. The revenue and the associated expense is to be reported in this discrete 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.

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	9030-9039
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 for Individual Sessions	9135-9139
Preschool - Special Education Itinerant Teacher (SEIT) Services for Group Sessions of 2 Students	9140-9144
Preschool - Special Education Itinerant Teacher (SEIT) Services for Group Sessions of 3 or More Students	9145-9149
Preschool - Integrated Special Class – over 2.5 hours per day	9160-9163
ECE 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
Early Intervention Program All Services	9300
Early Intervention Program Initial Service Coordination	9301
Early Intervention Program Ongoing Service Coordination	9302
Early Intervention Program Screenings	9310
Early Intervention Program Core Evaluations	9311
Early Intervention Program Physician Evaluations	9312
Early Intervention Program Supplemental Evaluations	9313
Early Intervention Program Home/Community Based Individual Collateral Services	9320
Early Intervention Program Office/Facility Based Individual Collateral Services	9330
Early Intervention Program Group Developmental Intervention Services	9341
Early Intervention Program Parent/Child Group Services	9342
Early Intervention Program Family/Caregiver Support Group Services	9343
4204 State Supported Deaf Infant Program (ages 0-2)	9315
Federal Grants	9800-9802, 9804 & 9807-9810
Teacher Certification Grant	9803
Section 611 LEA Suballocation	9805
Section 619 LEA Suballocation	9806
Smart School/Instructional Technology NYS Grant	9811

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 Individuals with Intellectual Disabilities (ICF/IID). 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/IID 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.

9030-9039 - **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 for Individual Sessions**

Individual 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 childcare location, as defined in Section 200.16(h)(3)(ii) of the Commissioner's Regulations.

9140-9144 - Preschool-Special Education Itinerant Teacher (SEIT) Services for Group Sessions of 2 Students

Group services, in which 2 students are present, 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 childcare location, as defined in Section 200.16(h)(3)(ii) of the Commissioner's Regulations.

9145-9149 – Preschool-Special Education Itinerant Teacher (SEIT) Services for Group Sessions of 3 or More Students

Group services, in which 3 or more students are present, 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 childcare location, as defined in Section 2001.6(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/ECE 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 Division of Early Care and Education (ECE), 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 childcare 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 - Early Intervention Program All Services

This program code should only be used for Agencies that cannot break out NYS Early Intervention Program (Part C IDEA) revenue and expenses by the new program codes (9301 – 9343). Agencies must choose to use just 9300 for all NYS Early Intervention Program (Part C IDEA) revenue and expenses reporting or choose to break out NYS Early Intervention Program (Part C IDEA) revenue and expenses by the new rate codes (9301 – 9343).

Units of Service: Not applicable

9301 – Early Intervention Program Initial Service Coordination

Report all revenue and expenses relating to delivering service initial coordination service for the NYS Early Intervention Program (Part C IDEA). Initial Service coordination is service coordination provided on or before the initial IFSP meeting for eligible children and all service coordination services for children found ineligible or children referred to the program a who did not go on to receive an initial IFSP.

Units of Service: Billable 15-minute increments

9302 – Early Intervention Program Ongoing Service Coordination

Report all revenue and expenses relating to delivering ongoing service coordination service for the NYS Early Intervention Program (Part C IDEA). Ongoing Service coordination is service coordination provided after the initial IFSP meeting for eligible children.

Units of Service: Billable 15-minute increments

9310 – **Early Intervention Program Screenings**

Report all revenue and expenses relating to delivering screening services for the NYS Early Intervention Program (Part C IDEA).

Units of Service: Per screening

9311 – **Early Intervention Program Core Evaluations**

Report all revenue and expenses relating to delivering Core Evaluation services for the NYS Early Intervention Program (Part C IDEA).

Units of Service: Per Core Evaluation

9312 – Early Intervention Program Physician Evaluations

Report all revenue and expenses relating to delivering Physician Evaluation services for the NYS Early Intervention Program (Part C IDEA).

Units of Service: Per Physician Evaluation

9313 – **Early Intervention Program Supplemental Evaluations**

Report all revenue and expenses relating to delivering Supplemental Evaluation services for the NYS Early Intervention Program (Part C IDEA).

Units of Service: Per Supplemental Evaluation

9320 – Early Intervention Program Home/Community Based Individual Collateral Services

Report all revenue and expenses relating to delivering Home/Community Individual Collateral services for the NYS Early Intervention Program (Part C IDEA).

Units of Service: Per service visit

9330 – **Early Intervention Program Office/Facility Based Individual Collateral Services**

Report all revenue and expenses relating to delivering Office/Facility Based Individual Collateral services for the NYS Early Intervention Program (Part C IDEA).

Units of Service: Per service visit

9341 – Early Intervention Program Group Developmental Intervention Services

Report all revenue and expenses relating to delivering Group Developmental Intervention Services for the NYS Early Intervention Program (Part C IDEA). These services are authorized and billed as Basic and Enhanced group services either with or without the use of a 1:1 Aide.

Units of Service: Per Group service

9342 – Early Intervention Parent/Child Group Services

Report all revenue and expenses relating to delivering Parent/Child Group Services for the NYS Early Intervention Program (Part C IDEA).

Units of Service: Per Group service

9343 – Early Intervention Family/Caregiver Support Group Services

Report all revenue and expenses relating to delivering Family/Caregiver Support Group Services for the NYS Early Intervention Program (Part C IDEA).

Units of Service: Per Group service

Miscellaneous

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 and 9807-9810 - 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.

9811 – Smart School/Instructional Technology NYS Grant

State funding provided to enhance and improve provider's educational technology and infrastructure for their students.

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 ACCES 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 CFR-2 in Column 9 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 and Janitorial and Housekeeping Staff	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
Cafeteria Staff	Meals Served

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 programs, and agency administration must be reported in the "Other Programs" Column (Column 9) 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, SED, DOH and OCFS 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, SED, DOH and OCFS 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 8.0 (FAQ) 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 51) do not include the expenses of programs 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 64 through 70. Operating expenses for the following programs are to be deducted from agency-wide operating costs (CFR-3, lines 43 through 51):

- For OMH, operating expenses for programs coded 0860, 0870, 1230, 1690, 2740, 2850, 2860, 2980, 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 65.

- For OPWDD, operating expenses for program code 0190 are deducted from CFR-3, line 45. The adjusted total is entered on CFR-3, line 66.

- For SED, operating expenses for programs coded 9800-9811 are deducted from CFR-3, line 46. The adjusted total is entered on CFR-3, line 67.

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
DOH	CFR-1	0	0	0	0	0	0	0
OCFS	CFR-1	0	0	0	0	0	0	0
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
2740	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
DOH	CFR-1	0	0	0	0	0
OCFS	CFR-1	0	0	0	0	0
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 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	DOH Subtotal	0
48	OCFS Subtotal	0
49	Shared Programs Subtotal	264,300
50	Other Programs Subtotal	113,000
51	Total Agency Operating Costs	3,422,400

Calculation of Ratio Value Factor		
52	Net Agency Administration (CFR-3, line 42)	495,330
53	Total Agency Operating Costs (CFR-3, line 51)	3,422,400
54	Ratio Value Factor (line 52 divided by line 53)	.144731

Allocation of Agency Administration Using Ratio Value		
55	OASAS Allocation (line 43 x line 54)	39,251
56	OMH Allocation (line 44 x line 54)	70,151
57	OPWDD Allocation (line 45 x line 54)	214,087
58	SED Allocation (line 46 x line 54)	117,233
59	DOH Allocation (line 47 x line 54)	0
60	OCFS Allocation (line 48 x line 54)	0
61	Shared Programs Allocation (line 49 x line 54)	38,253
62	Other Programs Allocation (line 50 x line 54)	16,355
63	Total Agency Administration (sum lines 55 – 62)	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, 1230, 1690, 2740, 2850, 2860, 2980, 6920, 8810 and programs with an "A" program code index (startup) are deducted from CFR-3, line 44. Also, expenses for SED programs coded 9800-9811 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 2740. The figure shown on line 65 below is calculated as follows: $484,700 (total operating costs for OMH programs) minus $75,000 (total operating costs for the Program Coded 2740) = $409,700.

Line No.	State Agency	Operating Costs
Calculation of Adjusted Operating Costs		
64	OASAS Adjusted Subtotal	271,200
65	OMH Adjusted Subtotal	409,700
66	OPWDD Adjusted Subtotal	1,479,200
67	SED Adjusted Subtotal	810,000
68	DOH Adjusted Subtotal	0
69	OCFS Adjusted Subtotal	0
70	Shared Programs Adjusted Subtotal	264,300
Calculation of Adjusted Ratio Value Factor (transfer to the item description column of CFR-1, line 65)		
71	OASAS Allocation (line 55 divided by line 64)	.144732
72	OMH Allocation (line 56 divided by line 65)	.171227
73	OPWDD Allocation (line 57 divided by line 66)	.144732
74	SED Allocation (line 58 divided by line 67)	.144732
75	DOH Allocation (line 59 divided by line 68)	0
76	OCFS Allocation (line 60 divided by line 69)	0
77	Shared Programs Allocation (line 61 divided by line 70)	.144732

The Adjusted Ratio Value Factor calculated on lines 71 through 77 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 2740 is an exempt program type):

CFR-1 Line #	Expense	OMH 2100 Program	OMH 2740 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 21.0 for more specific instructions for claiming agency administration costs.

Note: An agency administration worksheet is available in CFRS Web 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.

See Appendix FF for allocation methodologies relating to specific OPWDD programs. The methodologies included in Appendix FF should be applied **after** the methodologies detailed in this appendix have been used to allocate costs between shared programs that cross state agencies and/or OPWDD programs. (For example, if staff is shared by an HCBS Group Day Habilitation Service (Program Code 0204) and an HCBS Supervised IRA (Program Code 0231), the staff should be allocated between these programs using the methodologies described in Appendix J. Once these expenses have been allocated using the Appendix J methodologies, the HCBS Group Day Habilitation Service (Program Code 0204) expenses can be allocated to Program Code 0092 - Day Services for Individuals Residing in an Intermediate Care Facility using the methodology described in Appendix FF.)

Shared Staff

1. Actual Hours of Service

Actual hours of service is the preferred statistical basis upon which to allocate salaries and fringe benefits for staff who are jointly shared between State agencies, or who work at multiple program/sites. Providers must maintain appropriate documentation (e.g., payroll records) reflecting the hours used in this allocation.

Example: **Allocation based on hours** (the preferred method)**:**

Agency XYZ employs a direct care worker who works at a Day Habilitation program and an IRA program. The standard work week for this person is forty (40) hours. Payroll records indicate 25 hours/week are spent at Site A (Day Habilitation program) and 15 hours/week at Site B (IRA program). 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.

2. Time Studies

If the preferred method cannot be utilized, allocations based on time studies will be accepted. 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: Acceptable time study allocation:

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.

3. Housekeeping and Janitorial Staff

For housekeeping and janitorial staff who serve more than one program, compensation and fringe benefits may be allocated according to the square footage of the space the staff is maintaining. An example of square footage allocation is given under the heading *Capital and Related Costs*.

4. Cafeteria Staff

To allocate costs of cafeteria staff compensation and benefits, the provider may use meals served as the allocation methodology. Provider should maintain documentation to support the meals served to individuals participating in the various programs. This documentation is also used for allocation of food costs.

Example: Allocation based on meals served

Agency XYZ maintains cafeteria service that is utilized by participants of Programs A, B, and C. The number of total meals provided over the course of provider's reporting period is 20,000. Participants consumed 5,000 meals in Program A, 7,000 in Program B and 8,000 in Program C. Total salaries for cafeteria staff are $175,000. They are allocated as follows:

Program A - $175,000 (cafeteria staff salaries) X 5,000/20,000 = $43,750
Program B - $175,000 (cafeteria staff salaries) X 7,000/20,000 = $61,250
Program C - $175,000 (cafeteria staff salaries) X 8,000/20,000 = $70,000

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.

SED Only: Units of Service Allocation may not be used for Special Education Itinerant Teacher (SEIT) programs.

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.

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 is not reasonable, the Agency Provider may determine a more reasonable method of allocation.

For example, a service provider may need to allocate supplies and materials costs to several program/sites. The recommended allocation method noted above is units of service. However, not all programs calculate the units of service using the same criteria and some programs are not required to report units of service at all. A reasonable alternative might be to allocate the supplies and materials costs using the ratio value method.

e.g. Total supplies and materials costs to be allocated to programs = $36,000

Total operating costs of programs prior to allocation of the supplies and materials costs = $480,000

Ratio Value: 36,000/480,000 = 7.5%
The supplies and material costs allowed for each program will be 7.5% of the program's operating costs prior to allocation of the supplies and materials costs.

Program	Operating Costs	Supplies & Materials Allocation
1	$210,000	$15,750
2	$110,000	$ 8,250
3	$160,000	$12,000
Total	$480,000	$36,000

Cost Allocation Guidance for Mixed-Use Integrated Housing Projects (OMH Only)

The Office of Mental Health (OMH) recognizes that, in many integrated, mixed-use housing projects, OMH funding and/or Empire State Supportive Housing Initiative (ESSHI) funds are being utilized within projects with mixed funding sources and/or multiple populations. However, there are certain funding sources that may be limited or targeted to serve specific populations. OMH understands that integrated mixed-use housing programs include low-income residents and are intended to operate in a unified fashion to support independent living in the community. As such, there are basic support and services that will have some tangential benefit to the low-income residents who are at risk of homelessness and face other similar life challenges to those with a mental illness. OMH believes that integrated housing models are the preferred approach, and services to clients should not be managed in a segregated manner that would be administratively burdensome and have the adverse impact of countering the intent of the program supports to the residents.

Therefore, when operating integrated, mixed-use housing projects, Supportive Housing providers need to demonstrate an acceptable approach to accounting for the appropriate use of funds. OMH will consider a logical methodology to cost allocation that is based on data (e.g. time studies, staff caseloads, per unit basis, etc.). In the case of a per unit basis, cost allocations and contract close-out reconciliations will be calculated proportionally by actual filled bed utilization according to the funded populations served under separate contracts. (Note that this approach would not apply to a single ESSHI contract that is serving multiple populations.)

The allocation methodologies detailed below relates to cost allocations within a Mixed-Use Integrated Housing Project with OMH funding. These methodologies are not meant to supersede attempts to direct charge an expense, nor are they meant to supersede the methodologies detailed in Appendix J to allocate costs between shared programs that cross state agencies and/or between programs funded by a state agency. The allocation methodology is meant to fairly distribute costs between multiple contracts/funding streams that are reported as part of a single program/site on the OMH schedules. For example, if staff is shared by Program Code 1760-Advocacy/Support Services and an integrated, mixed-use housing project with OMH funding, allocate the staff expense between the programs using the methodologies described in Appendix J. Once the staff expense has been allocated between the two programs per Appendix J, the methodologies described below may be used to proportionally allocate costs to the different populations served under separate contracts within the mixed-use housing program.

Example:

A mixed-use affordable and supportive single-site housing project could contain units that are ESSHI, scattered site Supportive Housing, and/or other non-OMH housing subsidy programs. In that instance, staff could be providing support services to individuals who are supported by any one of those funding streams. A case manager's salary and fringe could be allocated across multiple funding sources based on either:

1) the proportion of units in the building funded by each applicable source: If 20% of the supportive housing units in the building are ESSHI-funded, charge 20% of the case manager's salary and fringe to ESSHI, or

2) the proportion of individuals on a case manager's case load by each funding source supporting the units in which they are residing. If a case manager's caseload of 15 consists of 5 Supportive Housing (SH) funded individuals and 10 ESSHI-funded individuals, then the case manager's salary and fringe could be allocated at 33.33% to SH and 66.67% to ESSHI.

OMH reserves the right to review the calculation of the alternative methodologies and may request additional information to confirm that costs are appropriately allocated. Alternative methodologies must be consistently applied from year-to-year.

COVID-19 – Special Considerations

Due to the COVID-19 pandemic, allocation methods defined in Appendix J above, such as time studies, may not be feasible. Therefore, the following guidelines are to be used only after all attempts have been made in applying the methodologies described in Appendix J above (and Appendix FF for OPWDD providers):

Shared Staff
- Allocate clinical salaries by direct care hours between program/site
- Allocate direct care salaries by billable service hours/units
- Allocate support salaries on a historical basis

Other than Personal Services
- Allocate expenses based on number of individuals in program if all sites were treated equal regarding site preparedness for COVID related expenses
- Allocate expenses based on ratio value of operating direct expenses
- Allocate expenses based on billable service hours/units

If the recommended allocation method is not reasonable, the Agency Provider may determine a more reasonable method of allocation.

We reserve the right to review the calculation of the alternative methodologies and may request additional information to confirm that costs are appropriately allocated. These methods will only be allowed during this public health emergency due to the unprecedented nature of the COVID-19.

Please note, that the additional allocation methods listed in this section of Appendix J (COVID-19 – Special Considerations) are **only allowed if** a direct charge or an allocation method listed in the (1) other sections of Appendix J or (2) Appendix FF (OPWDD providers) is not possible.

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 and 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, Computer 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 audited 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**

The historical allocated percentages between the Department of Mental Hygiene (DMH) agencies for the LGU administration expenses and revenues are being discontinued for Upstate 2011 and NYC 2011-12 reporting cycles. Counties should report the administrative expense required for each DMH agency based upon calculations in this Appendix and representative of the administrative activities in the county. All DMH agencies have indicated that there will be no additional funding available for any changes in these expenses above State funding already being received.

The Federal Office of Management and Budget (OMB), Code of Federal Regulations, Title 2, Subtitle A, Chapter II, Appendix V to Part 200 - State/Local Governmentwide Central Service Cost Allocation Plans establishes plans for reimbursing state and local governments for central service costs incurred in administering federally funded programs.

The following are some key general guidelines; however, providers should review the complete OMB guidelines found in Appendix V to Part 200 - State/Local Governmentwide Central Service Cost Allocation Plans.

1. Most governmental units provide certain services, such as motor pools, computer centers, purchasing, accounting, etc., to operating agencies on a centralized basis. Since federally supported awards are performed within the individual operating agencies, there needs to be a process whereby these central service costs can be identified and assigned to benefitted activities on a reasonable and consistent basis. The central service cost allocation plan provides that process. All costs and other data used to distribute the costs included in the plan should be supported by formal accounting and other records that will support the propriety of the costs assigned to Federal awards.

2. Guidelines and illustrations of central service cost allocation plans are provided in a brochure published by the Department of Health and Human Services entitled "*A Guide for State, Local and Indian Tribal Governments: Cost Principles and Procedures for Developing Cost Allocation Plans and Indirect Cost Rates for Agreements with the Federal Government."* A copy of this brochure may be obtained from the HHS Cost Allocation Services or at their website: https://www.hhs.gov/about/agencies/asa/psc/indirect-cost-negotiations/index.html

Submission Requirements

1. Each state will submit a plan to the Department of Health and Human Services for each year in which it claims central service costs under Federal awards. The plan should include (a) a projection of the next year's allocated central service cost (based either on actual costs for the most recently completed year or the budget projection for the coming year), and (b) a reconciliation of actual allocated central service costs to the estimated costs used for either the most recently completed year or the year immediately preceding the most recently completed year.

2. Each major local government is also required to submit a plan to its cognizant agency for indirect costs annually.

3. All other local governments claiming central service costs must develop a plan in accordance with the requirements described in this Part and maintain the plan and related supporting documentation for audit. These local governments are not required to submit their plans for Federal approval unless they are specifically requested to do so by the cognizant agency for indirect costs. Where a local government only receives funds as a subrecipient, the pass-through entity will be responsible for monitoring the subrecipient's plan.

4. All central service cost allocation plans will be prepared and, when required, submitted within six months prior to the beginning of each of the governmental unit's fiscal years in which it proposes to claim central service costs. Extensions may be granted by the cognizant agency for indirect costs on a case-by-case basis.

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.

Providers with 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.

Note: There are two specific exceptions to using time studies methodologies. The exceptions for cafeteria staff and/or housekeeping and janitorial staff are described in Appendix J.

RESERVED FOR FUTURE USE

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 Attachment B of the fully executed contract.

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

Index	Definition	Fund Source
S	General Fund	State
E	Empire State Supportive Housing Initiative	State
G	Problem Gambling Services	State
F	SAPT Block Grant	Federal
C	Various Categorical Grants	Federal

DMH Code #	OMH/ OASAS* Only Index	Description
001		**Local Assistance – Regular State/Federal** - (OMH, OPWDD - Article 41, Section 18(b), Title E, MHL). Local governments are granted State Aid for approved net operating costs pursuant to an approved local services plan at the rate of 50% of the amount incurred during the local fiscal year by the local governments and volunteer agencies pursuant to a contract. **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	S, E, G, F, C	**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 provision of substance use disorder treatment, compulsive gambling, prevention, or other authorized services.
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 and direct contracts between OMH and provider agencies. Approved costs are funded at the rate of 100% State participation.
020		**Direct Sheltered Workshop** – (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.

DMH Code #	OMH/ OASAS* Only Index	Description
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 people with disabilities.
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.
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	A	**Legislative – New York State Psychiatric Association** – (OMH Only)
038	B	**Legislative – Medical Society of the State of New York** – (OMH Only)
038	C	**Legislative – National Association of Social Workers New York State Chapter** – (OMH Only)
038	E	**Legislative – North Country Behavioral Healthcare Network** – (OMH Only)
038	F	**Legislative – Veteran Peer-to-Peer Pilot Programs** – (OMH Only)
038	G	**Legislative – Demo Program for Counties** – (OMH Only) - Demonstration program for counties impacted during state fiscal crisis year 2011-12 by the closure of state-operated hospitals licensed under Section 7.17 of the Mental Hygiene Law.

DMH Code #	OMH/ OASAS* Only Index	Description
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	I	**Legislative – Member Items 001** – (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	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.
041	H	**Federal CMHS Adult COVID Relief Funds (OMH Only)** - This funding should address unmet need and capacity growth consistent with NYS expenditure plan approved by SAMHSA.
041	Z	**Federal CMHS Adult American Rescue Plan Funds (OMH Only)** - This funding should address unmet need and capacity growth consistent with NYS expenditure plan approved by SAMHSA.
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.
044	C	**Federal CMHS Kids COVID Relief Funds (OMH Only)** - This funding should address unmet need and capacity growth consistent with NYS expenditure plan approved by SAMHSA.
044	S	**Federal CMHS Kids American Rescue Plan Funds (OMH Only)** - This funding should address unmet need and capacity growth consistent with NYS expenditure plan approved by SAMHSA.
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	G	**C & F Emergency Services** – (OMH Only)
046	L	**C & F Community Support Programs** – (OMH Only)
046	M	**Mott Haven Community** – (OMH Only)
046	N	**Child and Family Clinic Plus (State Aid)** – (OMH Only)
048	A	**Homeless MI (PATH)** – (OMH Only)
048	C	**New York/New York (PATH)** – (OMH Only)

DMH Code #	OMH/ OASAS* Only Index	Description
049	B	**Federal HUD Shelter Plus Care** – (OMH Only) where funds flow through OMH only. Other cases, use code 062.
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)
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/Supportive 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	A	**Supportive Housing Stipend Increase** – (OMH Only)
078	G	**New York/New York III Supportive Housing** – (OMH Only)
078	Z	**Single Room Occupancy (SRO)** – (OMH Only) - Operating costs for Supported SRO related to 99/00 additions.
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)
096	A	**Community Based Family Care General** – (OMH Only) 100% State funded.

DMH Code #	OMH/ OASAS* Only Index	Description
096	K	**Home and Community-Based Services Waiver – General** – (OMH Only)
096	O	**Adult HCBS General** – (OMH Only)
096	Z	**Adult HCBS Medicaid** – (OMH Only)
111		**Federal Drug Free Schools and Communities Act** – (OMH C&F Community Support Program) - 100%
112		**Outpatient State Aid** – (OMH Only) - 100% Net Deficit Funding for licensed Outpatient Programs (Clinic Treatment, Day Treatment, Partial Hospitalization, Intensive Psychiatric Rehabilitation Treatment)
115		**Residential – Adult Operating** – (OMH Only)
115	D	**Residential – Program Development** – (OMH Only)
115	P	**Residential – Adult Property** – (OMH Only)
116		**Residential – Children Operating** – (OMH Only)
116	P	**Residential – Children Property** – (OMH Only)
119	A	**Federal Forensic Initiatives** – (OMH Only) - Various Federal funds for enhanced services for Forensic Community Programs.
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%)
142	A	**Expanded Community Support Adult** – (OMH Only)
142	B	**Expanded Community Support C&Y (Children and Youth)** – (OMH Only)
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 known 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.
158		**Transformation Opportunities** – (OPWDD Only)
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%)
171	A	**Mental Illness Anti-Stigma** – (OMH Only)
175	A	**Article 28 and 31 Closure Re-investments (Adult)** – (OMH Only)
175	B	**Article 28 and 31 Close Re-investments (Children and Youth)** – (OMH Only)
178		**Adult Home Court Ordered** – (OMH Only) - 100% Net Deficit Funding for programs operating as a result of the Adult Home Litigation (Supportive Housing, Supportive Housing Services, Outreach).

DMH Code #	OMH/ OASAS* Only Index	Description
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.
192		**DSP**– (OPWDD Only)
200		**Community Reinvestment Services Fund** – (OMH Only)
200	C	**Supportive Housing Workforce RIV** – (OMH Only - 100%)
300		**Homeless Mentally Ill Fund** – (OMH Only)
400		**Commissioner's Performance Fund** – (OMH Only - 100%)
531		**Empire State Supportive Housing Initiatives (ESSHI)** – (OPWDD Only)
540		**Co-Occurring Disorders** – (OMH Only)
541		**Managed Care Demonstration Programs** – (OMH Only - 100%)
560	A	**Behavioral Health Organization** – (OMH Only)
570		**Health Home Care Management** – (OMH Only)
570	K	**Children and Youth Health Home Care Management** – (OMH Only)
575		**Empire State Supportive Housing Initiatives (ESSHI)** – (OMH Only)
575	B	**Empire State Supportive Housing Initiatives for Scattered Sites** – (OMH Only)
580		**Medicaid Redesign Team (MRT) Supportive Housing Beds** – (OMH Only)
590		**OPWDD COLA (OPWDD Only)**
650		**Minimum Wage Adjustment** – (OPWDD Only)
965		**Workforce COLA** – (OMH Only)
965	S	**Personnel Services Enhancements** – (OMH Only)

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.

- Costs incurred that extend the useful life of an existing asset or substantially increase its' productivity must be capitalized and depreciated if $5,000 or greater.

- 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.

- Assets purchased with State and Federal monies (other than funds received via rates, prices, fees or net deficit funding) cannot be depreciated on the CFR. Where applicable, the revenue and depreciation expense associated with these assets should be reported as reconciling items on the Reconciliation. For CFR purposes, the depreciable basis is calculated by subtracting the salvage value and the amount funded by State or Federal monies from the total cost of the asset.

- 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.

OASAS Note: The above guidance only applies to the cost reporting schedules (core schedules) of the CFR. OASAS does not allow its service providers to budget or claim any type of depreciation expense. Any depreciation expense that is reported for OASAS programs in the core schedules of the CFR, must be adjusted out of the Schedule DMH-2.

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. The latest edition of this document can be purchased 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

In general, amortization is the process of allocating the cost of an intangible asset over a period of time. Except where otherwise stated by the funding State agency, intangible assets are reported on the CFR in accordance with U.S. GAAP.

The CFR does not include schedules that calculate the amortization expense. However, the 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

Examples include but are not limited to:

- **Leasehold improvements in operating leases** which are the responsibility of the service provider under the terms of a lease are amortized over the shorter of the useful life of the assets or the remaining term of the lease.

- **Software purchased for internal use or developed for internal use** which is amortized over the useful life of the software.

- **Loans such as mortgages and related mortgage costs** which are amortized using straight line.

- **Capital leases** which are amortized in a manner consistent with the lessee's normal depreciation policy for owned assets or over the lease term.

- In **accounting for pension benefits or other postretirement benefits,** amortization is the systematic recognition in net periodic pension cost or other postretirement benefit cost over several periods of amounts previously recognized in other comprehensive income, that is, gains or losses, prior service cost or credits, and any transition obligation or asset.

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 (for example, 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, 6060 would become 6060 A0 for a Supportive Housing program receiving Start-up funds).

These guidelines are to be utilized by all OMH providers who operate Community Residence (CR) programs or other residential programs which have Exempt Income. The procedures for reporting Exempt Income 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.

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 and expenditures from exempt income will be reported in the appropriate expense category (lines 5 through 10 of Schedule DMH-2). 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.

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 Owed

OMH is authorized to recover from providers, up to 50% of the Medicaid Fee for Service income that exceeded the fixed amount of annual Medicaid revenue projection of the CR program(s).

The Medicaid ***Exempt Income Owed*** to OMH is calculated separately for (1) Adult CR program codes 6070 and 7070 and (2) Child CR program codes 7050.

The following steps are used to determine the amount of ***Medicaid Exempt Income Owed*** back to OMH.

Step 1: Calculate the *Net Exempt Income*:

For the period, compare the total amount paid for the Medicaid Fee for Service claims for the CR program(s), to the Medicaid revenue budgeted for the CR program(s) on the Gross Income Net (GIN) program model(s).

If ***Medicaid Claims Paid*** exceed the ***GIN Medicaid***, 50% of the excess is the ***Net Exempt Income***.

Step 2: Calculate the *Adjusted Net GAAP Revenue*:

Exclude ***Net Exempt Income*** from ***Net GAAP Revenue***.

Full CFR: The ***Net GAAP Revenue*** from Schedule CFR-1, line 100 is used in the calculation.

Abbreviated or Article 28 Abbreviated CFR: The ***Net GAAP Revenue*** reported on Schedule DMH-1, line 36 is used in the calculation.

Step 3: Calculate the *Surplus/Deficit*:

Subtract ***Total Adjusted Expenses*** from the ***Adjusted Net GAAP Revenue***.

Full CFR: The ***Total Adjusted Expenses*** from Schedule CFR-1, line 67 is used in the calculation.

Abbreviated or Article 28 Abbreviated CFR: The ***Total Adjusted Expenses*** from Schedule DMH-1, line 14 is used in the calculation.

Step 4: Calculate the Medicaid *Exempt Income Owed*:

If the CR program ***Deficit*** is less than ***Net Exempt Income***, then the CR program ***Deficit*** will be subtracted from ***Net Exempt Income*** and the remainder will be owed.

If the CR program ***Deficit*** is greater than or equal to the ***Net Exempt Income***, then no Medicaid Exempt Income will be owed.

If there is not a CR program ***Deficit,*** then ***Net Exempt Income*** will be the amount owed.

Illustration: Calculation of Medicaid Exempt Income Owed

Line ID	Short Description	Long Description	Formula	Adult	Child
A	**Total Adjusted Expense**	CFR1 line 67 (Prog Codes 6070, 7070, 7050, 4040).		$ 631,269	$ 2,200,357
B	**Net GAAP Revenue**	CFR1 line 100 (Prog Codes 6070, 7070, 7050, 4040).		$ 651,849	$ 2,011,351
C	**Medicaid Claims Paid**	eMedNY claims with Dec-Nov (Upstate/LI) or Jun-May (NYC) service dates. CR Enhancement claims are not included.		$ 526,314	$ 1,794,072
D	**GIN Medicaid**	Minimum program standard (found on last page of CR GIN).		$ 486,181	$ 1,748,199
E	**Gross Exempt Income**	Medicaid revenue exceeding minimum program standards.	C - D	$ 40,133	$ 45,873
F	**Net Exempt Income**	50% of Gross Exempt Income.	E * 50%	$ 20,067	$ 22,936
G	**Adjusted Net GAAP Revenue**	Net GAAP Revenue excluding Net Exempt Income.	B - F	$ 631,782	$ 1,988,415
H	**Surplus (+) or Deficit (-)**	Adjusted Net GAAP Revenue minus Total Adjusted Expenses.	G - A	$ 513	$ (211,942)
I	**Adjustment to Net Exempt Income***	Amount to be reduced from the Net Exempt Income.	*See Below	$ -	$ (22,936)
J	**Exempt Income Owed**	Amount owed after Deficit is applied to Net Exempt Income.	F + I	**$ 20,067**	**$ -**

Grand Total	$ 20,067

***Notes:**

- If the CR Program ***Deficit*** is greater than ***Net Exempt Income***, the adjustment will be a reduction equal to the ***Net Exempt Income***.
- If the CR Program ***Deficit*** is less than or equal to ***Net Exempt Income***, the adjustment will be a reduction equal to the CR Program ***Deficit***.
- If there is **no** CR Program ***Deficit,*** the adjustment will be **$0**.

Reporting Medicaid *Exempt Income Owed* on the Consolidated Fiscal Report:

Full CFR Submission

If the Medicaid ***Exempt Income Owed*** to OMH was included as revenue on:

- Schedule CFR-1, line 72a, Medicaid Fee for Service, ***then*** also report it on Schedule CFR-1, line 104, on a line labeled "Community Residence (CR) Exempt Income owed to OMH for current period".

- Schedule DMH-2, line 17a, Medicaid Fee for Service, ***then*** also report it on Schedule DMH-2, line 39, on the predefined line 'Community Residence (CR) Exempt Income owed to OMH for current period".

Abbreviated and Article 28 Abbreviated CFR Submissions

If the Medicaid ***Exempt Income Owed*** to OMH was included as revenue on:

- Schedule DMH-1, line 18a, Medicaid Fee for Service, ***then*** also report it on Schedule DMH-1, line 40, on a line labeled, 'Community Residence (CR) Exempt Income owed to OMH for current period".

- Schedule DMH-2, line 17a, Medicaid Fee for Service, ***then*** also report it on Schedule DMH-2, line 39, on the predefined line, 'Community Residence (CR) Exempt Income owed to OMH for current period".

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
Behavior Intervention Specialist 1	340
Behavior Intervention Specialist 2	341
Behavioral Support Staff (SED Only) – replaces Crisis Intervention Worker	243
Broker – Start-Up and Support	357
Care Manager Assistant/Associate Health Home Care Management or Basic HCBS Plan Support (OPWDD Only)	303
Case Manager (Does not apply to SED)	301
Certified Recovery Peer Advocate – CRPA and CRPA - Provisional (OASAS and OMH Only)	208
Clinical Coordinator (Does not apply to OPWDD)	342
Community Relations	610
Chief Financial Officer/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 – QIDP – Clinical (OPWDD Only)	309
Developmental Disabilities Specialist – QIDP - Direct Care (OPWDD Only)	207
Dietician/Nutritionist (OMH, OPWDD and OASAS Only)	336
Director of Division	604
Early Recognition Specialist (ERS) (OMH Only)	356
Emergency Medical Technician (Does not apply to SED)	312
Executive Director/Chief Executive Officer	601
Family Support Navigator (OASAS Only)	209

Position Title	Position Title Code
Food Service Worker (OASAS and OPWDD use 336 for Dietician/Nutritionist)	101
Guidance Counselor (SED Only)	236
Housekeeping and Maintenance	102
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
Lead Care Manager Health Home Care Management or Basic HCBS Plan Support (OPWDD Only)	302
Licensed Mental Health Counselor (OASAS, OMH and OCFS Only)	327
Licensed Psychoanalyst (OMH Only)	328
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
Nurse's 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 Professional – Non-CRPA (OASAS Only)	210
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/Site Worker (Does not apply to SED)	202
Residential Treatment Facility (RTF) Transition Coordinator (OMH Only)	352
Security	105
Senior Counselor (OMH CR Only)	205
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
Staff Training (Program/site) (OPWDD and SED only)	347

Position Title	Position Title Code
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
Volunteer Coordinator (OASAS Only)	211

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/Site 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, Site Manager.
203	Counselor (OMH CR Only)	All individuals who perform this role as defined in the OMH Community Residence Program Model.
204	Manager (OMH CR Only)	All individuals who perform this role as defined in the OMH Community Residence Program Model.
205	Senior Counselor (OMH CR Only)	All individuals who perform this role as defined in the OMH Community Residence Program Model.
206	Supervisor (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
207	Developmental Disabilities Specialist QIDP – 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.
208	Certified Recovery Peer Advocate – CRPA and CRPA – Provisional (OASAS and OMH Only)	A person holding an active CRPA certification and is functioning in a professional peer role in a program.
209	Family Support Navigator (OASAS Only)	A person who helps families navigate systems, learn from lived experience of other families, and provides informational and educational support.
210	Peer Professional – Non-CRPA (OASAS Only)	A person who does not hold a CRPA certification or may hold a certification other than CRPA or no certification and is functioning in a professional peer role in a program.
211	Volunteer Coordinator (OASAS Only)	A person who manages all elements of individuals that are **volunteering** within the organization.
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 titles 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 a teacher 50 percent or more of his or her assignment in such capacity. Pursuant to Part 80 of the Regulations of the Commissioner of Education, a school administrator and supervisor serving greater than 25% (10 periods/week) of his or her assignment in any administrative or supervisory position must have valid administrative certification. If supervising more than 50 percent of assignment, see Code 518. For SEIT programs, the time a teacher spends performing the duties of a SEIT teacher must be reported using code 218 and the time a teacher spends directly supervising SEIT teachers must be reported using 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.

CODE NUMBER	POSITION TITLE/ JOB TITLE(S)	DEFINITION
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.
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 ACCES'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) (Does not apply to SED)	An individual credentialed by the New York State Office of Addiction Services and Supports.
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 Addiction Services and Supports.
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.
302	Lead Care Manager Health Home Care Management or Basic HCBS Plan Support (OPWDD Only)	An individual employed by a Care Coordination Organization (CCO), who provides care management services in accordance with either the Health Home Care Management or the Basic HCBS Plan Support model. Care Managers must meet the qualifications identified in the Care Coordination Organization/Health Home Policy Manual.
303	Care Manager Assistant/Associate Health Home Care Management or Basic HCBS Plan Support (OPWDD Only)	An individual employed by a Care Coordination Organization (CCO), who assists in providing care management services in accordance with either the Health Home Care Management or the Basic HCBS Plan Support model. The Care Manager Assistant role is outlined in an OPWDD Memorandum dated 9/26/18 (CCO/HH Provider Policy Guidance and Manual Updates). Care Manager Assistant/Associate qualifications will be further outlined in forthcoming regulations and policy guidance. (These individuals are not required to meet the Care Manager qualification requirements and work under the supervision of a qualified Care Manager.
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 QIDP – 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.

CODE NUMBER	POSITION TITLE/ JOB TITLE(S)	DEFINITION
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.
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. (The supervision requirement above does not apply to SED)
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.

CODE NUMBER	POSITION TITLE/ JOB TITLE(S)	DEFINITION
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.
324	Social Worker – Licensed (LMSW, LCSW)	Individuals, who are licensed in this discipline by SED and who are engaged in the provision of routine social work. 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.
327	Licensed Mental Health Counselor (OASAS, OMH & OCFS Only)	Individuals licensed as a Licensed Mental Health Counselor by the NYS Education Department. These individuals use assessment instruments, provide mental health counseling and psychotherapy, clinical assessment and evaluation, treatment planning and case management, prevention, discharge and aftercare services.
328	Licensed Psychoanalyst (OMH Only)	Individuals licensed as a Licensed Psychoanalyst by the NYS Education Department. These individuals use assessment instruments and mental health counseling and psychotherapy to identify, evaluate and treat dysfunctions and disorders for the purpose of providing appropriate psychoanalytic services. Psychoanalysts use the relationship between the patient and the analyst as an essential tool to promote emotional growth and healthy functioning through changes in the patient's character.
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.
340	Behavior Intervention Specialist 1 (OPWDD Only)	An individual who assists in the implementation of behavior interventions, supports and services. This position requires a master's from a clinical field of psychology, social work or applied psychology and training in assessment; or BCBA and master's in behavior analysis or closely related field; or a NYS license in mental health counseling with appropriate experiences.
341	Behavior Intervention Specialist 2 (OPWDD Only)	An individual who assists in the implementation of behavior interventions, supports and services. This position requires a BCBA and master's in behavior analysis or closely related field; or a master's in clinical treatment field or NYS license in mental health counseling and have approved specialized training in FBAs and BSPs; or bachelor's in human services field, and experience, and is actively working towards graduate degree in applied psychology, social work or special education.
342	Clinical Coordinator (Does not apply to OPWDD)	Responsible for overseeing clinical aspects of the program, including staff supervision and case review.

CODE NUMBER	POSITION TITLE/ JOB TITLE(S)	DEFINITION
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.
350	Pharmacist (Does not apply to SED)	Licensed by SED and responsible for dispensing medications.
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.

CODE NUMBER	POSITION TITLE/ JOB TITLE(S)	DEFINITION
356	Early Recognition Specialist (ERS) (OMH Only)	An individual who supports the early identification of childhood mental illness through the creation and maintenance of productive partnerships, community outreach, child and family engagement, active parental consent and carrying out a community-wide plan for early identification. This position requires as minimum education requirement, a bachelor's degree in a major or concentration of social work, psychology, nursing, rehabilitation, education, occupational therapy, physical therapy, recreation or recreation therapy, counseling, community mental health, child and family studies, sociology, speech and hearing; or a NYS teacher's certificate for which a bachelor's degree is required; or NYS licensure and registration as a Registered Nurse and a bachelor's degree. It is also expected that the individual will have a minimum of two years (with a master's degree or higher) or four years (with a bachelor's degree) of experience providing direct services to children with emotional disturbance and their families.
357	Broker – Start-Up and Support (Does not apply to SED)	This title is used for all variants of Consolidated Supports and Services (CSS) and Self-Directed services. The Broker assists the individual to develop and maintain a complete and approvable CSS Plan/Self-Directed Budget taking into account the desired value outcomes.
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.
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.

CODE NUMBER	POSITION TITLE/ JOB TITLE (S)	DEFINITION
518	Supervising Teacher (SED Only)	Provides for direct supervision of teachers. Certified administrator or supervisor of special education programs if serving more than 50 percent of his or her assignment in such capacity. Pursuant to Part 80 of the Regulations of the Commissioner of Education, a school administrator and supervisor serving greater than 25% (10 periods/week) of his or her assignment in any administrative or supervisory position must have valid administrative certification. For SEIT programs, all the time a teacher spends directly supervising SEIT teachers must be reported using this code. Certification requirements detailed above apply.
520	Staff Training (Program Administration)	An individual responsible for the training of program staff. (**OPWDD and SED**: Use Code 347).
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		
CODE NUMBER	**POSITION TITLE/ JOB TITLE (S)**	**DEFINITION**
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	Chief Financial Officer/ 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.

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.

RESERVED FOR FUTURE USE

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 1.0 through 9.0 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 audited and certified financial statements.

Refer to Section 2.0 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. Refer to Section 3.0 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. Refer to Section 4.0 for more detailed information about CFR due dates.

CFRS Web

All Abbreviated CFRs must be created and submitted using CFRS Web. Refer to Section 5.0 and Section 9.0 for more information about CFRS Web.

Financial Statements

Submission of audited and 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 audited and certified financial statements:

Abbreviated CFR Type	Financial Statements Required? Yes/No
Abbreviated CFR	Yes
Mini-Abbreviated CFR	No
Article 28 CFR	Yes

Refer to Section 6.0 for more detailed information about audited and 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-2A, CFR-4, CFR-5, CFR-6, DMH-1, COVID-19	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
	COVID-19	Accrual Only
Claim:	DMH-2, DMH-3	Accrual, Modified Accrual or Cash

Article 28 Abbreviated CFR		
	Schedules	**Method of Accounting Allowed**
Core:	CFR-4, DMH-1, COVID-19	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.

Refer to Section 7.0 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. The CFR-iv certification schedule is required as part of an Abbreviated or Article 28 Abbreviated CFR submission of Not-For-Profit and Proprietary providers submitting to Office of Addiction Services and Supports (OASAS), Office of Mental Health (OMH) and Office for People With Developmental Disabilities (OPWDD).

The CFR-iv schedule is <u>not required</u> for:
- Governmental service providers
- Mini-Abbreviated CFRs

The required certification schedules must be submitted to each funding NYS agency and funding county, if funded through a local county contract. For NYS agency submission instructions, refer to Section 2.0 of the CFR Manual. For funding county submission instructions, contact the funding county.

Note: The Independent Accountants Report (Schedule CFR-ii/iiA) is not required for submission with Abbreviated, Mini-Abbreviated or Article 28 Abbreviated CFRs.

Refer to Sections 10.0 through 12.0 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, provider agency definition and program site(s) definitions must be completed in CFRS Web.

The recommended order of completion for each type of Abbreviated CFR is as follows:

<u>Abbreviated Submissions</u>:

- CFR-4, DMH-1, CFR-2, Admin. Worksheet, CFR-5, CFR-2A, CFR-6, DMH-2, DMH-3, Reconciliation, COVID-19.

  Note: The CFR-6 is not required to be completed by service providers who are funded and/or certified by OMH only.

  The Reconciliation must be completed only when the reporting periods of the CFR and financial statements are the same.

<u>Mini-Abbreviated Submissions</u>:

- CFR-4, CFR-5, Admin. Worksheet, DMH-2, DMH-3, COVID-19

<u>Article 28 Abbreviated Submissions</u>:

- CFR-4, DMH-1, DMH-2, DMH-3, COVID-19

Instructions for Completing the Abbreviated CFR

1. **CFR-4**: Section 16.0 has detailed instructions on completing Schedule CFR-4.

   The program site portion of Schedule 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). CFRS Web will bring totals forward automatically. Schedule CFR-4, agency administration, should also be completed at this time.

2. **DMH-1**: Section 20.0 has detailed instructions on completing Schedule DMH-1.

   Expenses from the DMH-1 carry forward to the CFR-2. OASAS program expenses are carried 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 8.

3. **CFR-2**: Section 14.0 has detailed instructions on completing Schedule CFR-2.

   All of the expense lines for CFR-2, Column 9, Other Programs, except the Agency Administration Allocation, are completed using the fiscal information contained in your agency's general ledger. The fiscal information in CFR-2, Column 9 will reflect the expenses of your agency's activities that are not listed in columns 2 through 8.

4. **Admin. Worksheet**: Complete the Agency Administration Worksheet using the instructions found in Appendix T under the section "Allocating Agency Administration by Ratio Value".

5. **CFR-5**: Section 18.0 has detailed instructions on completing Schedule CFR-5.

6. **CFR-2A**: Section 14.0 has detailed instructions on completing Schedule CFR-2A.

7. **CFR-6**: Section 19.0 has detailed instructions on completing Schedule CFR-6.

8. **DMH-2**: Section 22.0 has detailed instructions on completing Schedule DMH-2.

   Transfer all items of expense and revenue from the DMH-1 to the DMH-2. Make the adjustments necessary to accommodate an accounting method other than accrual accounting. If subsequent changes are made to CFR-4 or DMH-1 for a program, then the transfer of all items of expense and revenue from DMH-1 to DMH-2 for that program must be repeated.

   OMH – Administrative costs can be allocated using a method other than the Ratio Value methodology.

   OASAS and OPWDD – Administrative costs are allocated using the Ratio Value methodology.

9. **DMH-3**: Section 23.0 has detailed instructions on completing Schedule DMH-3.

10. **Reconciliation**: Section 14.0 has detailed instructions on completing the Reconciliation of Revenues/Gains and Expenses/Losses.

11. **COVID-19**: Section 33B has detailed instructions on completing COVID-19 Informational Schedule.

Instructions for Completing the Mini-Abbreviated CFR

1. **CFR-4**: Section 16.0 has detailed instructions on completing Schedule CFR-4.

   The program site portion of Schedule 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). CFRS Web will bring totals forward automatically. Schedule CFR-4, agency administration staff, should also be completed at this time.

2. **CFR-5**: Section 18.0 has detailed instructions on completing Schedule CFR-5.

3. **Admin. Worksheet**: Complete the Agency Administration Worksheet using the instructions found in Appendix T under the section "Allocating Agency Administration by Ratio Value".

4. **DMH-2**: Section 22.0 has detailed instructions on completing Schedule DMH-2.

   Expense lines are completed using the fiscal information contained in your agency's general ledger.

   Enter the allocated amount of agency administration and the revenue for each program reported on the appropriate lines of Schedule DMH-2.

   OASAS, OMH and/or OPWDD funding received via direct contract or local contract is reported as Net Deficit Funding.

5. **DMH-3**: Section 23.0 has detailed instructions on completing Schedule DMH-3.

6. **COVID-19**: Section 33B has detailed instructions on completing COVID-19 Informational Schedule.

Instructions for Completing the Article 28 Abbreviated CFR

1. **CFR-4**: Section 16.0 has detailed instructions on completing Schedule CFR-4.

   Complete the program-site portion of Schedule CFR-4 so the total amount paid for personal services can be brought forward to the Personal Services line on Schedule DMH-1 (line 6). CFRS Web will bring totals forward automatically. Article 28 hospitals and Article 31 hospitals are not required to complete the agency administration section of the CFR-4 schedule.

2. **DMH-1**: Section 20.0 has detailed instructions on completing Schedule DMH-1.

   Enter the agency administration expenses for each program reported on the appropriate lines of each State Agency's DMH-1. Article 28 hospitals and Article 31 hospitals may use the same step-down methodology used in their Institutional Cost Report (ICR).

   OASAS, OMH and/or OPWDD funding received via direct contract or local contract is reported as Net Deficit Funding.

DMH-2: Section 22.0 has detailed instructions on completing Schedule DMH-2.

Transfer all items of expense and revenue from DMH-1 to DMH-2. Make the adjustments necessary to accommodate an accounting method other than accrual accounting. If subsequent changes are made to CFR-4 or DMH-1 for a program, then the transfer of all items of expense and revenue from DMH-1 to DMH-2 for that program must be repeated.

OMH – Administrative costs can be allocated using a method other than the Ratio Value methodology.

OASAS and OPWDD – Administrative costs can be allocated using the Ratio Value methodology.

3. **DMH-3**: Section 23.0 has detailed instructions on completing Schedule DMH-3.

4. **COVID-19**: Section 33B has detailed instructions on completing COVID-19 Informational Schedule.

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 reported on the Abbreviated and Mini-Abbreviated CFRs are calculated by taking the sum of personal services, vacation leave accruals, fringe benefits and OTPS.

Note: CFRS Web 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 OASAS, OMH, OPWDD and all other programs.

Abbreviated CFR: The worksheet requires the Provider Agency to enter an amount for Line 8, Net Agency Administration (see Step 2 below).

Mini-Abbreviated CFR: The worksheet requires the Provider Agency to enter an amount for Line 6, Other Programs Subtotal, and Line 8, Net Agency Administration (see Step 2 below).

Step 1 **Abbreviated CFRs**: CFRS Web will calculate 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. The results are reflected in the Agency Administration Worksheet, Line 1, 2, 3, 5 and 6.

Mini-Abbreviated CFRs: CFRS Web will calculate the operating costs for each State Agency by adding lines 5 through 8 in DMH-2 for all the State Agency's programs. The results are reflected in the Agency Administration Worksheet, Line 1, 2 and 3.

Note: Operating Costs for programs 0880 and 0890 are excluded from the calculations of Total Agency Operating Costs on the Agency Administration Worksheet.

Subcontract raw materials reported for program 0340 should be excluded from the calculations of Total Agency Operating Costs on the Mini-Abbreviated CFR.

Step 2 **Line 6, Other Programs Subtotal (Mini-Abbreviated CFRs only)**:
Enter the total operating costs of the Provider Agency for all non-CFR programs. The Provider Agency must calculate the total operating costs for all non-CFR programs from its general ledger.

Line 8, Net Agency Administration (Mini-Abbreviated CFRs and Abbreviated CFRs):
Enter the net agency administration costs of the Provider Agency on Line 8 of Agency Administration Worksheet. The Provider Agency must calculate the total agency administration expenses from its general ledger, subtracting any non-allowable expenses as detailed in Appendix X.

Step 3 **Allocation of Agency Administration Using Ratio Value**:
Abbreviated CFRs: CFRS Web will calculate each State Agency's total share of agency administration and allocate it between the eligible programs on Schedule DMH-1, Line 12, using the Ratio Value Factor multiplied by the program's operating costs. The Agency Administration Costs of ineligible programs are redistributed to the eligible programs.

Mini-Abbreviated CFRs: CFRS Web will calculate each State Agency's total share of agency administration and allocate it between the eligible programs on Schedule DMH-2, Line 11, using the Ratio Value Factor multiplied by the program's operating costs. The Agency Administration Costs of ineligible programs are redistributed to the eligible programs.

The following charts represent the calculation and allocation of agency administration expenses by ratio value for an agency completing an Abbreviated CFR.

Exhibit 1
Calculation of Operating Costs for XYZ, Inc.
From Schedule CFR-2

Column		1	2	3	4	5	6	7	8	9
Line #	Expenses	Agency Totals	OASAS Totals	OMH Totals	OPWDD Totals	SED Totals	DOH Totals	OCFS Totals	Shared Program Totals	Other Program Totals
1	Personal Services	144,000	29,000	75,000						40,000
2	Vac. Leave 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 Costs		200,000	40,000	100,000						60,000

Exhibit 2
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

Exhibit 3
Allocation of Agency Administration by Ratio/Value for XYZ, Inc.
For Schedules CFR-2 and DMH-1

Column	1	2	3	4	5	6	7	8	9
	Agency Totals	OASAS Totals	OMH Totals	OPWDD Totals	SED Totals	DOH Totals	OCFS 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

Exhibit 4
Calculation of OMH Program-Specific Operating Costs for XYZ, Inc.
From Schedule DMH-1 OMH Programs

Column		1	2
Line #	Expenses	Program 1760	Program 0770
6	Personal Services	40,500	34,500
7	Vac. Leave Accruals		
8	Fringe Benefits	6,480	5,520
9	OTPS	7,020	5,980
MINUS Raw Materials			
Total Operating Costs		54,000	46,000

Exhibit 5
Allocation of Agency Administration to OMH Programs by Ratio/Value
For Schedule DMH-1 OMH Programs

Column	1	2
	Program 1760	Program 0770
Total Operating Costs (See Fig. 3 above)	54,000	46,000
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	OMH	OPWDD	Total
Allegany	48,946	$ 2,290	$ 6,057	$16,653	$25,000
Cattaraugus	80,317	343	7,962	16,695	25,000
Cayuga	80,026	0	5,600	19,400	25,000
Chautauqua	134,905	0	25,000	0	25,000
Chemung	88,830	3,750	6,500	14,750	25,000
Chenango	50,477	3,000	12,000	10,000	25,000
Clinton	82,128	1,600	11,900	11,500	25,000
Columbia	63,096	0	12,500	12,500	25,000
Cortland	49,336	2,300	9,400	13,300	25,000
Delaware	47,980	1,900	4,400	18,700	25,000
Essex	39,370	10,000	10,000	5,000	25,000
Franklin	51,599	0	25,000	0	25,000
Fulton	55,531	4,000	18,000	3,000	25,000
Genesee	60,079	3,000	16,000	6,000	25,000
Greene	49,221	0	11,000	14,000	25,000
Hamilton	4,836	6,902	14,025	4,073	25,000
Herkimer	64,519	3,300	20,500	1,200	25,000
Jefferson	116,229	5,000	18,000	2,000	25,000
Lewis	27,087	0	12,500	12,500	25,000
Livingston	65,393	0	25,000	0	25,000
Madison	73,442	5,000	10,000	10,000	25,000
Montgomery	50,219	3,000	22,000	0	25,000
Ontario	107,931	1,300	11,600	12,100	25,000
Orleans	42,883	5,000	15,000	5,000	25,000
Oswego	122,109	5,000	15,000	5,000	25,000
Otsego	62,259	5,000	10,000	10,000	25,000
Putnam	99,710	3,896	14,400	6,704	25,000
Rensselaer*	159,429	8,540	13,036	3,425	25,000
Schenectady	154,727	12,500	12,500	0	25,000
Schoharie	32,749	4,729	3,973	16,298	25,000
Schuyler	18,343	2,000	11,500	11,500	25,000
Seneca	35,251	1,500	4,750	18,750	25,000
St. Lawrence	111,944	12,500	12,500	0	25,000
Steuben	98,990	6,645	6,968	11,387	25,000
Sullivan	77,547	1,900	4,900	18,200	25,000
Tioga	51,125	3,000	12,700	9,300	25,000
Tompkins	101,564	8,333	8,334	8,333	25,000
Ulster	182,493	2,300	14,800	7,900	25,000
Warren*	65,707	5,927	17,220	1,855	25,000
Washington*	63,216	6,103	17,188	1,710	25,000
Wayne	93,772	1,284	8,948	14,768	25,000
Wyoming	42,155	14,300	10,700	0	25,000
Yates	25,348	0	8,800	16,200	25,000
TOTAL		$167,142	$538,161	$369,701	$1,075,000

OASAS Note: Effective 01/01/2009 OASAS no longer funds any programs based on the 50 percent calculation with local governments as outlined in Mental Hygiene Law 41-18 (section b). Any counties becoming eligible for the enhanced State Aid percentage after 01/01/2009 will not receive additional funding from OASAS, although the calculation may be displayed in the above Appendix U. Any newly eligible counties will be designated with an asterisk (*).

For those counties with a population under 200,000 as calculated prior to 01/01/2009, OASAS continues to support our portion of the enhanced State Aid with the additional funding added to the 0890 LGU Administration program.

These guidelines are to be utilized by all counties who receive Federal Medicaid Administration Reimbursement (FMAR) program revenue from OASAS, OMH and/or OPWDD (the Offices). Through participation in the FMAR program, counties can be reimbursed for part of the local governmental cost, reported in program code 0890-Local Governmental Unit (LGU) Administration, for (a) the wage and fringe benefit costs of the LGU employee(s) associated with the administration of the mental hygiene portion of the Medicaid program and/or (b) the subcontractors who administer the mental hygiene portion of the Medicaid program.

Note: The Offices outsource certain Medicaid Administration Reimbursement process functions to a vendor. The vendor operates a Random Moment Time Study (RMTS); maintains and updates roster inclusion for the RMTS; collects and reviews LGU cost reports; provides quarterly training and annual refreshers to all LGUs and monitors a hot line for Medicaid Admin LGU questions. The Offices require that each LGU have a designated representative for communication with the Offices and the vendor. Claims are submitted by OMH to the Department of Health (DOH) for final submission to the Center for Medicaid and Medicare Services (CMS). Upon adjudication of claim(s) by CMS and subsequent sub allocation from DOH, OMH will make payment to the LGUs via miscellaneous voucher(s).

CFR Reporting Provisions

The LGU Administration program (0890) is reported as a shared program on the CFR core schedules (CFR-1 through CFR-6 and DMH-1). For State Aid claiming purposes, LGU Administration expenses and revenues are separately reported to OASAS, OMH and/or OPWDD on Schedules DMH-2 and DMH-3.

FMAR program revenue may be used for county or NYCDOHMH operated mental hygiene services only, and must be reported when reimbursed, on the CFR claim schedules of the County LGU or municipality in either:

- A mental hygiene LGU Administration program (program 0890); or

- Any other OASAS, OMH and/or OPWDD-funded, county/NYCDOHMH operated mental hygiene program (i.e., programs that receive State Aid funding through OASAS, OMH and/or OPWDD funding sources).

The FMAR program revenue is divided among the Offices in the same percentages that the reimbursed expenses were previously divided among the Offices: (1) statewide claim percentage (OASAS 16%, OMH 78%, and OPWDD 6%) or; (2) percentages representative of the administrative activities in the county.

The FMAR program revenue is reported on the CFR on Schedules CFR-1, line 94; DMH-1, line 30; and/or DMH-2, line 29.

OMH providers should also review the Federal Medicaid Administration Reimbursement, Spending Plan Guidelines, for additional instructions on claiming.

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 ½ 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 NY Codes, Rules and Regulations (NYCRR) are silent, OASAS, OMH, OPWDD, DOH and OCFS will defer to the guidelines published in the Provider Reimbursement Manual, commonly referred to as PRM-15.

OPWDD providers should also refer to Appendix EE for Reimbursement Principles.

SED providers should refer to the SED Reimbursable Cost Manual for specific items that are not allowable for SED programs.

A cost must be reasonable and/or necessary for providing services in both its nature and amount. In determining the reasonableness of a given cost, consideration will be given to whether the costs incurred in rendering the services is generally recognized as ordinary and necessary for the operation of the organization and the restraints or requirements imposed by Federal and State laws and regulations. Unreasonable and/or unnecessary costs are not allowable.

Except where otherwise indicated in the CFR Manual, costs determined not to be in accordance with U.S. generally accepted accounting principles are not allowable.

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 or non-monetary contribution to another individual or organization (for example, political contributions, charitable contributions, etc.).

4. Costs applicable to services, facilities and supplies furnished to the provider by a related organization**,** as defined in Section 18.0 of the CFR manual, are excluded from the allowable cost of the provider if they exceed 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.

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 from the appropriate state agency office.

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

9. 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.

10. Costs related to the purchase of alcoholic beverages.

11. 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.

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

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

14. 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.

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

16. 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 state agency.

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

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

19. 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.

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

21. Agency payment of individual employee professional licensing and/or credentialing fees.

22. Where appropriate, costs that need approval by the Division of Budget and approval has not been received.

23. Fringe benefit expenses that are not reasonable and available to all employees including but not limited to Supplemental Executive Retirement Plans or any Non-Qualified Deferred Compensation Plans subject to IRC Subsection §457(f).

24. That portion of the cost of company-furnished automobiles that relates to personal use by employees (including transportation to and from work) is not allowable regardless of whether the cost is reported as taxable income to the employees.

    OPWDD: Refer to Appendix EE for Reimbursement Principles regarding the use of automobiles for personal use.

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

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

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

28. Costs of insurance on the lives of trustees, officers, or other employees holding positions of similar responsibilities are allowable only to the extent that the insurance represents additional compensation. The cost of such insurance when the organization is identified as the beneficiary is not allowable.

29. Rental costs under leases which are required to be treated as capital leases under GAAP are allowable only up to the amount that would be allowed had the organization purchased the property or asset on the date the lease agreement was executed. The provisions of FASB Accounting Standards Codification Section 840 shall be used to determine whether a lease is a capital lease. Non-allowable costs include amounts paid for profit, management fees, and taxes that would not have been incurred had the organization purchased the property or asset.

    OPWDD: Refer to 14 NYCRR Subpart 635-6 Allowability of Capital Costs and Costs of Transactions with Related Parties regarding costs allowable under capital leases and costs of transactions with related parties

30. Severance pay is not an allowable cost for OASAS. All other agencies impose limitations as detailed in Section 8.0 of the CFR Manual.

31. The following costs are not allowable on the CFR claiming schedules but are allowable on the CFR core schedules:

    a. 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 is not allowable unless the provider is owned and operated by members of a religious order and borrows from the Mother House or Governing Body of the religious order.

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

    c. For programs funded through Aid to Localities, costs representing capital additions or improvements are not allowable as operating expenses (Title 14 NYCRR) unless specifically authorized in a legislative appropriation.

d. For programs receiving funding through Aid to Localities, the costs associated with debt service, whether principal or interest are not allowable (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.

32. A goodwill impairment loss.

33. Costs of training afforded staff that does not relate to enhancing the performance of that staff in fulfillment of their duties to the organization.

34. Punitive damages, also known as “exemplary damages,” are a monetary amount awarded to a plaintiff, in excess of compensatory damages, in a civil lawsuit for the purpose of punishing the defendant for a reckless or willful act, or to deter the defendant from engaging in the same conduct in the future.

Hospitals receiving funds from Department of Mental Hygiene (DMH) via direct and/or indirect contracts are generally required to complete an Article 28 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 latest Institutional Cost Report (ICR) for the period submitted to the Department of Health - Office of Health Insurance Programs (OHIP). 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, documentation to support the methodology used to calculate the percentages must be available upon request.

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.

DMH General Policy Regarding In-Contract/Out-of-Contract Reporting

When the three (3) DMH State Agencies (OASAS, OMH and OPWDD) allocate 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.

OASAS Policy Regarding In-Contract/Out-of-Contract Reporting

OASAS funded service providers are not required to report any un-funded OASAS certified or non-certified programs they operate on the Consolidated Budget Reports (CBRs) unless specifically requested to do so by OASAS. However, year-end fiscal reporting policies and procedures are more expansive. Specifically, OASAS requires that service providers report all programs operational during the fiscal reporting period on all OASAS-specific Core schedules (CFR-1 through DMH-1) of their Consolidated Fiscal Report (CFR). In addition, a provider that receives State Aid funding for any OASAS program must report all programs operated (funded or not) on the Claiming Schedules (DMH-2 and DMH-3). If the provider does not operate any State Aid funded programs, they are not required to complete the Claiming schedules. This requirement applies to any and all combinations of the following:

- Funded certified programs
- Funded non-certified programs
- Un-funded certified programs

OASAS reserves the right to apply some or all of any surplus generated by a provider's funded and/or un-funded programs against the deficit of one (1) or more of that provider's funded programs thereby reducing total provider State Aid approved for the fiscal reporting period.

The following guidance is designed for use by an independent certified public accountant or an independent licensed public accountant who has 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 18, which supersedes SSAE 10 and 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.

For OPWDD providers, also refer to Appendix FF.

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 tests. 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 U.S. 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 certified public accountant or independent licensed 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 certified public accountant or independent licensed 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 certified public accountant or independent licensed 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/CFRManual/home.html

(2) Obtain an understanding of the service provider’s internal control structure and its 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 CFRS Web 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 prior cost report period and the end of the current cost report period.

(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:

(1) 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.

(2) Verify that OTPS, equipment and property expenses have been allocated to programs and sites using an acceptable allocation method as described in Appendix J. (OPWDD providers should also refer to Appendix FF.)

(3) 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 line 97-Provision for Bad Debts – Revenue Deduction and line 101 - Exempt Contract Income.

CFR-2--Agency Fiscal Summary - Procedures

(1) On a test basis, trace Column 9 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 audited and 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 CFRS Web. Confirm that the entries are appropriate.

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

CFR-2A--Agency Fiscal Data – Procedures

(1) Trace the amounts to the corresponding amounts in the financial statements that were submitted in accordance with section 2.0 and 6.0.

(2) For those amounts not identified in the financial statements, trace the amounts to the data from the underlying year-end-adjusted accounting records that support these financial statements.

(3) For Yes/No responses, verify the accuracy of the responses.

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 work week 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-5--Capital Schedule - Procedures

(1) On a test basis, trace the amounts reported in Column 1 to the DOH prepared supporting documentation.

(2) On a test basis, trace the amounts reported in Column 2 to the client prepared supporting documentation and ensure that these amounts have been properly reported and tie out to CFR-1.

(3) Obtain representation from management that, to the best of its knowledge and belief, the amounts reported in Column 4 are accurately explained in Column 5.

SED-1--Program and Enrollment Data - Procedures

On a test basis:

(1) Review the reasonableness of the reported FTEs in comparison to reported SED revenues and certified tuition rates.

(2) Trace FTEs by program on lines 100 and 107 to the client prepared supporting documentation.

(3) Determine that the school has calculated FTEs 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.

SUPP-1 – Upper Payment Limit (UPL) Data – Procedures

(1) Verify that the Provider agency name, agency code, site code, program code, MMIS billing number and CFR ending period are correct.

(2) On a test basis, trace visits by payor to client prepared supporting documentation.

(3) Trace gross revenue and net patient revenue to the agency's supporting documentation.

RESERVED FOR FUTURE USE

Local Governmental Units (LGUs) and municipalities, and other governmental entities 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), Department of Health (DOH) and Office of Children and Family Services (OCFS). 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, DOH and/or OCFS review and audit for a minimum of 7 years following DMH's, DOH's and/or OCFS'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, DOH and OCFS have specified and agreed to a set of procedures for the independent auditor to perform to satisfy the requirements of CFR Certification. Procedures a through j, 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-5, OMH-1 and SUPP-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 for 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 CFRS Web was used to prepare the CFR.

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, DOH and/or OCFS 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, DOH and/or OCFS.

CFR Agreed Upon Procedures Report Format

The following is the suggested Agreed Upon Procedures Report format:

Independent Accountant's Report
on Applying Agreed Upon Procedures

(Date of Report)

(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), New York State Department of Health (DOH) and/or New York State Office of Children and Family Services (OCFS) and in connection therewith, the LGU/municipality is required to report certain information to DMH, DOH and/or OCFS.

DMH, DOH and OCFS have established the following standards regarding 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, DOH and/or OCFS review and audit for a minimum of seven years following DMH's, DOH's and/or OCFS'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.

Management is responsible for the entity's compliance with the specified requirements.

We have performed the procedures enumerated below, which were agreed to by DMH, DOH and OCFS, the Organization, and the New York State governmental funding agencies (collectively, the specified parties), solely to assist in evaluating whether the Organization complied with the procedures enumerated below in relation to the accompanying CFR with the Documentation Control Number _____, for the year ended _____. The entity's management is responsible for the CFR records. The sufficiency of these procedures is solely the responsibility of the specified parties in the report. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

The following are our procedures related to 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-5, OMH-1 and SUPP-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 for 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 CFRS Web was used to prepare the CFR.

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 following information and findings came to our attention from performing the procedures described in this report. (Itemize all information and findings. If none, so state.)

The agreed upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. We were not engaged to and did not conduct an examination or review, the objective of which would be an expression of an opinion or conclusion, on compliance with specified requirements. Accordingly, we do not express such an opinion or conclusion. Had we performed additional procedures described above for the year ended _____ other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of specified parties and is not intended to be and should not be, used by anyone other than those specified parties.

(Manual or printed signature of the Practitioner's firm)

(City and State where the Practitioner practices)

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 7.0 of the CFR 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 17a - Medicaid Fee for Service 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 23.0 of the CFR 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 17a - Medicaid Fee for Service 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 23.0 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 17a - Medicaid Fee for Service 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 23.0 of the CFR 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 17a - Medicaid Fee for Service 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 23.0 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 17a - Medicaid Fee for Service 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 23.0 of the CFR 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 17a - Medicaid Fee for Service 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 23.0 of the CFR 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 23.0 of the CFR 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 17a – Medicaid Fee for Service:			
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

***** NOTICE *****

COPS/Level II COPS/CSP Medicaid Supplemental Rate Elimination: Per agreement with the Centers for Medicare and Medicaid Services, the COPS, Level II COPS and CSP Medicaid rate supplements have been eliminated. The effective dates of this action, by program type, are as follows:

COPS/Level II COPS
Partial Hospitalization: 7/1/12
Clinic Treatment (for COPS-only rate codes): 9/1/12
Continuing Day Treatment: 10/1/13
Day Treatment: 10/1/13
Intensive Psychiatric Rehabilitation Treatment: 10/1/13

CSP
Continuing Day Treatment: 10/1/13
Day Treatment: 10/1/13
Clinic Treatment: 11/1/13

OPWDD will not reimburse provider expenses that exceed the guidelines contained in this document.

Costs Eligible for Reimbursement by OPWDD

OPWDD uses the following principles to determine costs eligible for reimbursement:

(1) Any cost must be related to the provision of services to people with disabilities, the enhancement of agency staff skill and training, the direct provision of services to people with disabilities, or the operation of the agency.
(2) In order to be considered eligible for reimbursement, any cost is subject to the "prudent buyer" concept that the maximum spent should be what a typical buyer would reasonably expect to pay.

Meals

The cost of food and non-alcoholic beverages is allowable for:

(1) Employees providing direct services to people with disabilities during mealtimes,
(2) Employees while engaged in business-related travel up to the federal per diem limits published by the U.S. General Services Administration, and
(3) Board members while engaged in board related business travel up to the federal per diem limits published by the U.S. General Services Administration.

Costs incurred by staff providing direct services to people with disabilities 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.

Entertainment

Costs of no business benefit to the agency and related solely to the amusement and diversion of staff, administration, or board members are not eligible for reimbursement.

Costs incurred by staff in the provision of direct service to people with disabilities 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 people with disabilities 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 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

When considered lavish or extravagant according to the prudent buyer concept, the costs of office furnishings and decorations are not eligible for reimbursement. Fine art and collectibles are not eligible for reimbursement.

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 people with disabilities.

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.

The allocation methodologies detailed in this appendix relate to specific OPWDD programs. These methodologies should be applied **after** the methodologies detailed in Appendix J have been used to allocate costs between shared programs that cross state agencies and/or OPWDD programs. (For example, if staff is shared by 0227-HCBS Site Based Prevocational Services and Program Code 0231-HCBS Supervised IRA, allocate the staff expense between these programs using the methodologies described in Appendix J. Once the staff expense has been allocated using the Appendix J methodologies, Program Code 0227-HCBS Site Based Prevocational Services expenses can be allocated to Program Code 0094–Site Based Vocational Services for Individuals Residing in an Intermediate Care Facility using the methodology described below.)

1. Program Codes 0204/0205 Expense Allocation to Program Code 0092

Any provider that operates Program Code 0204-HCBS Group Day Habilitation Service (Certified Site) or Program Code 0205-HCBS Group Day Habilitation Service (Without Walls) which provides services to individuals who reside in an Intermediate Care Facility must report the expenses related to serving those individuals under Program Code 0092-Day Services for Individuals Residing in an Intermediate Care Facility.

In order to allocate the expenses between these programs, providers must use the following allocation methodology:

* All expenses for these programs reported on CFR-1, CFR-4 and CFR4A, with the exception of CFR-1, Property - Provider Paid (Lines 49-62), must be allocated between Program Codes 0204 or 0205 and 0092 based on units of service applicable to each program type.

* The portion of the Property – Provider Paid expenses (Lines 49-62) related to program administration must also be allocated between these programs based on units of service.

* The portion of the Property – Provider Paid expenses (Lines 49-62) not related to program administration must be reported under either Program 0204-HCBS Group Day Habilitation Service (Certified Site) or Program Code 0205-HCBS Group Day Habilitation Service (Without Walls) as applicable.

(Revenue is not allocated but is reported in each program according to the reimbursable units billed for each program.)

Example:

Step 1 - Units of Service - Program 0204 = 500
Units of Service - Program 0092 = 300

Step 2 - Total Units of Service (500 + 300) 800

Step 3 - Program 0204 = 500/800 = .625
Program 0092 = 300/800 = .375

Step 4 - Utility Expenses = $5,000

Program 0204 Allocation = $5,000 X .625 = $3,125
Program 0092 Allocation = $5,000 X .375 = $1,875

2. Program Code 0227 Expense Allocation to Program Code 0094

Any provider that operates Program Code 0227-HCBS Site Based Prevocational Services which provides services to individuals who reside in an Intermediate Care Facility must report the expenses related to serving those individuals under Program Code 0094–Site Based Vocational Services for Individuals Residing in an Intermediate Care Facility.

In order to allocate the expenses between these two programs, providers must use the following allocation methodology:

* All expenses for these programs reported on CFR-1, CFR-4 and CFR4A, with the exception of CFR-1, Property - Provider Paid (Lines 49-62), must be allocated between Program Codes 0227 and 0094 based on units of service applicable to each program type.

* The portion of the Property – Provider Paid expenses (Lines 49-62) related to program administration must also be allocated between these programs based on units of service.

* The portion of the Property – Provider Paid expenses (Lines 49-62) not related to program administration must be reported under Program Code 0227-HCBS Site Based Prevocational Services.

(Revenue is not allocated but is reported in each program according to the reimbursable units billed for each program.)

Example:

Step 1 - Units of Service - Program 0227 = 1000
Units of Service - Program 0094 = 600

Step 2 - Total Units of Service (1000 + 600) 1600

Step 3 - Program 0227 = 1000/1600 = .625
Program 0094 = 600/1600 = .375

Step 4 - Lease/Rental–Real Property (Program Admin) $10,000

Program 0227 Allocation = $10,000 X .625 = $6,250
Program 0094 Allocation = $10,000 X .375 = $3,750

3. Program Code 0203 Expense Allocation to Program Code 0095

Any provider that operates Program Code 0203-HCBS Community Based Prevocational Services program which provides services to individuals who reside in an Intermediate Care Facility must report the expenses related to serving those individuals under Program Code 0095-Community Based Vocational Services for Individuals Residing in an Intermediate Care Facility.

In order to allocate the expenses between these two programs, providers must use the following allocation methodology:

* All expenses for these programs reported on CFR-1, CFR-4 and CFR4A, with the exception of CFR-1, Property - Provider Paid (Lines 49-62), must be allocated between Program Codes 0203 and 0095 based on units of service applicable to each program type.

* The portion of the Property – Provider Paid expenses (Lines 49-62) related to program administration must also be allocated between these programs based on units of service.

* The portion of the Property – Provider Paid expenses (Lines 49-62) not related to program administration must be reported under Program Code 0203-HCBS Community Based Prevocational Services.

(Revenue is not allocated but is reported in each program according to the reimbursable units billed for each program.)

Example:

Step 1 -	Units of Service	-	Program 0203 = 1000
	Units of Service	-	Program 0095 = 600
Step 2 -	Total Units of Service (1000 + 600)		1600
Step 3 -	Program 0203 = 1000/1600	=	.625
	Program 0095 = 600/1600	=	.375

Step 4 - Lease/Rental–Real Property (Program Admin) $10,000

Program 0203 Allocation = $10,000 X .625 = $6,250
Program 0095 Allocation = $10,000 X .375 = $3,750

4. Allocation Methodologies for Site Specific Reporting applicable to ICF/IIDs, Supervised IRAs, Group Day Habilitation (Certified Sites and Without Walls) and Prevocational (Site Based)

Site Specificity Beginning with the CFR Period Indicated Below	ICF/IID 0090 and 1090	Supervised IRA 0231	Group Day Habilitation 0204 and 0205	Pre-Vocational Services (Site Based) 0227
January 1, 2015 - December 31, 2015	X	X		
July 1, 2015 - June 30, 2016	X	X	X	X

The following allocation methodologies may be used after all attempts have been made to direct charge an expense:

OTPS

OTPS Item	Recommended Allocation Method
Food	Units of Service
Repairs and Maintenance	Square Feet
Utilities	Square Feet
Transportation Related	Number of Trips or Miles
Staff Travel	Compensation Allocation *
Participant Incidentals	Direct Charge Only
Expensed Equipment	Compensation Allocation *
Staff Development	Compensation Allocation *
Supplies and Materials	Units of Service or Compensation Allocation *
Telephone	Number of Phones or Compensation Allocation *
Insurance-General	Ratio Value or Units of Service
Other	Units of Service or Compensation Allocation *

* **Compensation Allocation** - When an OTPS item (for example – cell phones or computers) can't be direct charged and the item is used by staff that work at multiple locations, the following methodology can be used:

Allocate OTPS items that are specific to staff that are being allocated across multiple sites using the same allowable allocation method as their compensation.

Capital and Related Costs

Equipment - Direct Charge Only (For Program Administration Related Equipment, use Ratio Value to allocate.)

Property - Direct Charge Only (For Program Administration Related Property, use Ratio Value to allocate.)

Shared Staff

After all attempts have been made to direct charge the compensation and fringe benefits, the following allocation methodologies may be used to allocate expenses from the program level to the site level:

Support

Housekeeping and Maintenance; Security - allocate according to the square footage of the space for which the staff is providing maintenance or security services.

Food Service Worker, Transportation Worker and Other - Units of Service **Direct Care**

202 – Residence/Site Worker - Based on DSP staff hours at each site. (Percent based on staff payroll and contracted employee hours worked.)

207 – DD Specialist QIDP Direct Care - Based on DSP staff hours at each site. (Percent based on staff payroll and contracted employee hours worked.)

All Other Direct Care - Complete Time Studies in accordance with Appendix J of the CFR Manual.

Clinical Staff - Based on Certified Capacity or DSP staff hours at each site.

Program Administration - Ratio Value or Unit of Service

Examples:

Compensation Allocation

RN for IRAs = $45,000 Annual Shared Salary

IRA A	Combined Direct Care hours from CFR-4 & CFR-4a	10,400
IRA B	Combined Direct Care hours from CFR-4 & CFR-4a	20,800
IRA C	Combined Direct Care hours from CFR-4 & CFR-4a	20,800
	Total	52,000

IRA A	10,400/52,000 = 20%	$45,000 X 20% = $ 9,000
IRA B	20,800/52,000 = 40%	$45,000 X 40% = $18,000
IRA C	20,800/52,000 = 40%	$45,000 X 40% = $18,000

Ratio Value

Total Expense to be Allocated (i.e.: Insurance General) $1,000

IRA A	Operating Cost $	40,000
IRA B	Operating Cost $	60,000
IRA C	Operating Cost $	60,000
	Total	$160,000

Ratio Value Factor $1,000/$160,000 = .00625

IRA A	$40,000 X .00625 = $250
IRA B	$60,000 X .00625 = $375
IRA C	$60,000 X .00625 = $375

For Providers that are approved to operate an Integrated Outpatient Services (IOS) clinic program, it continues to be necessary to report the IOS program on the Consolidated Fiscal Report (CFR) schedules to the New York State agencies that issued the underlying operating certificate/certification. This means that if:

1. The program was originally certified by OMH, the program must be reported on the OMH schedules of the CFR, even if the program has been designated as an "OASAS host" for the IOS clinic program.

2. The program was originally certified by OASAS, the program must be reported on the OASAS schedules of the CFR, even if the program has been designated as an "OMH host" for the IOS clinic program.

CFR Reporting

I. Integrated Outpatient Services Clinic

Whenever possible, providers should maintain discrete cost and service information by program/site, allowing them to monitor program finances, staff productivity and program utilization, as well as facilitating completion of the CFR. On the CFR, the IOS clinic is reported under program code 2100 for OMH, 3520 for OASAS and under program code 1580 for DOH.

Programs are required to maintain support demonstrating they have used a reasonable method of allocating costs. This requirement can be complied with through the use of accounting software or other sources that would provide support for the allocations reported within the CFR. An allocation between OMH, OASAS and DOH must be made if the provider operated both OMH and OASAS clinics, prior to being designated as an IOS clinic. The initial allocation between OMH/OASAS/DOH, if required, must be done in accordance with a methodology that is acceptable to OMH and OASAS. The following allocation methodologies have been determined to be acceptable:

a. **Allocation Method #1:** Providers may use the primary diagnosis on the billing to allocate the accrued revenue for the service(s) provided. The accrued revenue for all services provided to a client in a day are allocated to the NYS Agency based on the primary diagnosis on the billing or in the case where a service is not billed (e.g., charity care), the primary diagnosis for the service had it been billed: mental health/OMH, substance use/OASAS and primary care/DOH. The units of service (UOS), for the client served is allocated to the NYS Agency that the patient services revenue is allocated to. For the reporting period, accrued contributions and accrued other revenue (excluding State Aid), adjustments to revenue and the accrued expenses of the IOS clinic are allocated to OMH/OASAS/DOH in proportion to the total accrued patient services revenue allocated to each NYS Agency for the reporting period. State Aid that is part of a direct or local contract, is reported in full, on the CFR for the NYS Agency that provided the State Aid.

b. **Allocation Method #2:** Providers collect information on each clinical session, wherein the provider indicates whether the majority of time spent providing services in the session are related to mental health services (OMH), substance use disorder services (OASAS) or primary care services (DOH). The accrued revenue for all services provided to a client in a day are allocated to the NYS Agency that had the majority of time spent providing services in a day. In the event, the majority of time spent providing services to a client in a session, is equally split between providing mental health services (OMH), substance use disorder services (OASAS) and/or primary care services (DOH), then the primary diagnosis on the billing shall be used to determine the NYS Agency in which to allocate the patient services revenue for the session. The UOS, for the client served is allocated to the NYS Agency that the patient services revenue is allocated. For the reporting period, accrued contributions and accrued other revenue (excluding State Aid), adjustments to revenue and the accrued expenses of the IOS clinic are allocated to OMH/OASAS/DOH in proportion to the total accrued patient services revenue allocated to each NYS Agency for the reporting period. State Aid that is part of a direct or local contract, is reported in full, on the CFR of the NYS Agency that provided the State Aid.

Allocation Illustration:

IOS Clinic	Total	OMH	OASAS	DOH
Accrued Annual Patient Services Revenue	146,000	75,500	45,400	25,100
% of Total Patient Services Revenue	100.00%	51.71%	31.10%	17.19%
Accrued Annual Contributions and Other Revenue	55,000	28,441	17,105	9,454
State Aid - OASAS (net deficit funding)	5,000		5,000	
Accrued Annual Expenses	148,000	76,531	46,028	25,441

The application of the selected allocation methodology must be carried forth consistently throughout the reporting year.

Expenses that are shared between the IOS or Certified Community Behavioral Health Clinic (CCBHC) and another program, are first allocated to the respective programs in accordance with the instructions of the CFR Manual, before applying the expense allocation rules in this guidance.

Finally, the allocated UOS are reported on all applicable CFR schedules with the exception of Schedule OMH-4. On Schedule OMH-4, the **total UOS** by payor is reported, representative of the activities of the IOS clinic for the reporting period.

II. Certified Community Behavioral Health Clinic

All CCBHC providers are also IOS clinic providers. Accordingly, they should follow the guidance for IOS clinic reporting of revenue and expenses, unless an alternative methodology has been approved by OMH and OASAS.

Below is an alphabetical listing of DOH 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
Child & Youth HCBS Children's Waiver Community Habilitation	8100
Child & Youth HCBS Children's Waiver Day Habilitation	8110
Child & Youth HCBS Consolidated Waiver Caregiver/Family Supports & Services	2390
Child & Youth Consolidated Waiver Community Self-Advocacy Training and Supports	2400
Child & Youth HCBS Consolidated Waiver Crisis Respite	2380
Child & Youth HCBS Consolidated Waiver Planned Respite	2240
Child & Youth HCBS Consolidated Waiver Pre-Vocational Services	2360
Child & Youth HCBS Consolidated Waiver Supported Employment	2350
Integrated Outpatient Services (IOS) Clinic	1580
Palliative Care – Bereavement Service	2520
Palliative Care – Expressive Therapy	2510
Palliative Care – Massage Therapy	2530
Palliative Care – Pain and Symptom Management	2500

1580 – Integrated Outpatient Services (IOS) Clinic

The Integrated Outpatient Services program are authorized under DOH regulations 10 NYCRR Part 404. Integrated services providers of primary care services shall effectively meet patient physical health needs by (i) providing patient care in a continuous manner by the same health care practitioners for services, whenever possible; (ii) appropriately referring to other health care facilities or health care practitioners for services not available; (iii) identifying, assessing, reporting and referring cases of suspected or confirmed child abuse or maltreatment; (iv) identifying, assessing, reporting and referring cases of suspected of confirmed domestic violence; (v) ensuring that all staff receive education in the identification, assessment, reporting and referral of cases of suspected child abuse or maltreatment or domestic violence; and (vi) developing a written plan of treatment which shall be periodically revised, as necessary, in consultation with other health care professionals.

Units of Service: Count the number of visits.

2240 – Child & Youth HCBS Consolidated Waiver Planned Respite

The effective date of this program is April 1, 2019.

The Home and Community Based Services HCBS Waiver, authorized in 1915(c) of the Social Security Act, is to maintain individuals under the age of 21 with serious emotional disturbance SED in their homes and communities who would otherwise be in hospital levels of care by reimbursing for non-traditional services. Planned respite provides planned short-term relief for the child or family/primary caregivers that are needed to enhance the family/primary caregiver's ability to support the child/youth's functional, developmental, behavior health, and/or health care needs.

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

2350 – Child & Youth HCBS Consolidated Waiver Supported Employment

The effective date of this program is April 1, 2019.

The Home and Community Based Services HCBS Waiver, authorized in 1915(c) of the Social Security Act, is to maintain individuals under the age of 21 with serious emotional disturbance SED in their homes and communities who would otherwise be in hospital levels of care by reimbursing for non-traditional services. Supported employment services are individually designed to prepare and support a waiver participant, age 14 or older, to engage in paid work. These services are targeted to participants for whom employment without support at or above the minimum wage is unlikely. Services include assessment, counseling, job development and placement, on-the-job training, work skill training, ongoing supervision and monitoring, and ongoing support necessary to assure job retention.

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

2360 – Child & Youth HCBS Consolidated Waiver Pre-Vocational Services

The effective date of this program is April 1, 2019.

The Home and Community Based Services HCBS Waiver, authorized in 1915(c) of the Social Security Act, is to maintain individuals under the age of 21 with serious emotional disturbance SED in their homes and communities who would otherwise be in hospital levels of care by reimbursing for non-traditional services. Pre-Vocational services are individually designed to prepare and assist a waiver participant, age 14 or older, in acquiring and maintaining basic work and work-related skills necessary to acquire and retain competitive work in an integrated setting. Services may include vocational assessment, skills training, behavior management, problem solving, and the development of appropriate work attitudes and habits necessary for successful job performance.

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

2380 – Child & Youth HCBS Consolidated Waiver Crisis Respite

The effective date of this program is April 1, 2019.

The Home and Community Based Services (HCBS) Waiver, authorized in 1915(c) of the Social Security Act, is to maintain individuals under the age of 21 with serious emotional disturbance (SED) in their homes and communities who would otherwise be in hospital levels of care by reimbursing for non-traditional services. Crisis Respite is a short-term care and intervention strategy for children/youth and their families that helps to alleviate the risk for an escalation of symptoms, a loss of functioning, and/or a disruption in a stable living environment. It may be delivered in a home or residence by qualified practitioners, out of home/residence by staff in community-based sites, or in allowable facilities. Services include site-based crisis residence, monitoring for high risk behavior, health and wellness skill building, wellness activities, family/caregiver support, conflict resolution, and other services as needed.

Units of Service: Report using billable units. (i.e.: one quarter hour equals one unit of service.)
Note: Any per diem billing should be reported as 96 units.

2390 – Child & Youth HCBS Consolidated Waiver Caregiver/Family Supports & Services

The effective date of this program is April 1, 2019.

The Home and Community Based Services (HCBS) Waiver, authorized in 1915(c) of the Social Security Act, is to maintain individuals under the age of 21 with serious emotional disturbance (SED) in their homes and communities who would otherwise be in hospital levels of care by reimbursing for non-traditional services. This service enhances the individual's ability to function as part of a caregiver/family unit and enhances the caregiver/family's ability to care for the individual in the home and/or community. Services may include: interact and engage to offer educational, advocacy, and support resources to develop family's ability to independently access community services and activities; maintain and encourage self-sufficiency in caring for the individual in the home and community, and educate and train the caregiver unit on resource availability so that they might better support and advocate for the needs of the child and appropriately access needed services. This service is not the CFTSS Family Peer Support Service which is required to be delivered by a certified/credentialed Family Peer with lived experience.

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

2400 – Child & Youth HCBS Consolidated Waiver Community Self-Advocacy Training and Supports

The effective date of this program is April 1, 2019.

The Home and Community Based Services (HCBS) Waiver, authorized in 1915(c) of the Social Security Act, is to maintain individuals under the age of 21 with serious emotional disturbance (SED) in their homes and communities who would otherwise be in hospital levels of care by reimbursing for non-traditional services. This service provides family, caregivers, and collateral contacts with techniques and information not generally available so that can better respond to the needs of the participant. Services include: training for the individual and/or the family regarding methods and behaviors to enable success in the community; direct self-advocacy training in the community with collateral contacts regarding the needs related to the individual's health care issues and self-advocacy training for the individual and family during community transitions.

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

2500 – Palliative Care-Pain and Symptom Management

The effective date of this program is April 1, 2019.

The HCBS Waiver, authorized in 1915(c) of the Social Security Act, is to maintain individuals under the age of 21 in their homes and communities who would otherwise be in hospital levels of care by reimbursing for non-traditional services. This service is specialized medical care focused on providing relief from the symptoms and stress of a chronic condition or life-threatening illness. The goal is to improve quality of life for both the child and family. Pain and Symptom Management is an important part of aiding in providing relief from pain and symptoms and/or controlling pain, symptoms, and side effects related to chronic conditions of life-threatening illness a child is enduring. This management is not only an important part of humanely caring for the child's pain and suffering but helping the child and family cope and preserve their quality of life at a difficult time. This service is done in a 1:1 modality.

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

2510 – Palliative Care-Expressive Therapy
The effective date of this program is April 1, 2019.

The HCBS Waiver, authorized in 1915(c) of the Social Security Act, is to maintain individuals under the age of 21 in their homes and communities who would otherwise be in hospital levels of care by reimbursing for non-traditional services. This service is specialized medical care focused on providing relief from the symptoms and stress of a chronic condition or life-threatening illness. The goal is to improve quality of life for both the child and family. Expressive therapy (art, music and play) helps children better understand and express their reactions through creative and kinesthetic treatment. This service is done in a 1:1 modality.

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

2520 – Palliative Care-Bereavement Service

The effective date of this program is April 1, 2019.

The HCBS Waiver, authorized in 1915(c) of the Social Security Act, is to maintain individuals under the age of 21 in their homes and communities who would otherwise be in hospital levels of care by reimbursing for non-traditional services. This service is specialized medical care focused on providing relief from the symptoms and stress of a chronic condition or life-threatening illness. The goal is to improve quality of life for both the child and family. Bereavement Service helps the participants, and their families cope with grief related to the participant's end of life experience. Bereavement counseling services are inclusive for those participants in receipt of hospice care through a hospice provider. This service is done in a 1:1 modality; family is eligible to participate.

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

2530 – Palliative Care-Massage Therapy

The effective date of this program is April 1, 2019.

The HCBS Waiver, authorized in 1915(c) of the Social Security Act, is to maintain individuals under the age of 21 in their homes and communities who would otherwise be in hospital levels of care by reimbursing for non-traditional services. This service is specialized medical care focused on providing relief from the symptoms and stress of a chronic condition or life-threatening illness. The goal is to improve quality of life for both the child and family. Message therapy improves muscle tone, circulation, range of motion, and address physical symptoms related to illness as well as provide physical and emotional comfort, pain management, and restore the idea of healthy touch for children and youth who are dealing with treatments that may involve painful interventions and ongoing and/or past trauma. This service is done in a 1:1 modality.

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

8100 - Child and Youth HCBS Children's Waiver Community Habilitation

The effective date of this program is April 1, 2019.

Community Habilitation services includes face-to-face services and supports related to the child's acquisition, maintenance, and enhancement of skills related to activities of daily living, such as self-care, life safety, medication and health management, communication skills, mobility, community transportation skills, and social and adaptive skills necessary to maximize personal independence and integration in the community and enable the individual to reside in a non-institutional setting. Community Habilitation services may be provided on an individual or group basis. The provision of this service must be by qualified and designated practitioners.

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.)

8110 - Child and Youth HCBS Children's Waiver Day Habilitation

The effective date of this program is April 1, 2019.

Day Habilitation services provide assistance with acquisition, retention or improvement in self-help, socialization and adaptive skills including communication, and travel that regularly takes place in a non-residential setting, separate from the person's private residence or other residential arrangement. Group Day Habilitation Services are typically provided to two or more enrolled individuals. Group Day Habilitation Services may be provided on weekdays to a child at an OPWDD-certified setting typically between the daytime hours of 9:00 a.m. - to 3:00 p.m. Supplemental Group Day Habilitation Services are available for children who do not reside in a certified setting and are provided outside of the 9:00 a.m. – 3:00 p.m. weekday time period and includes later afternoon, evenings and weekends. The provision of this service must be by qualified and designated practitioners.

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.)

Below is an alphabetical listing of OCFS 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
Children & Family Treatment & Support Services: Community Psychiatric Support and Treatment (CPST) (Non-Licensed Program)	4950
Children & Family Treatment & Support Services: Family Peer Support Services (FPSS) (Non-Licensed Program)	4900
Children & Family Treatment & Support Services: Mobile Crisis Intervention (CI) (Non-Licensed Program)	4910
Children & Family Treatment & Support Services: Other Licensed Practitioner (OLP) (Non-Licensed Program)	4940
Children & Family Treatment & Support Services: Psychosocial Rehabilitation (PSR) (Non-Licensed Program)	4930
Children & Family Treatment & Support Services: Youth Peer Support (YPS)	4920

4900 - Children & Family Treatment & Support Services: Family Peer Support Services (FPSS) (Non-Licensed Program)

As a Medicaid funded Children's Health and Behavioral Health Services program, FPSS are an array of formal and informal activities and supports provided to families caring for/raising a child who is experiencing social, emotional, medical, developmental, substance use and/or behavior challenges in his/her life. FPSS provide a structured, strength-based relationship between a Family Peer Advocate (FPA) and the parent/family member/caregiver for the benefit of the child/youth. The need for this service must be determined by a licensed practitioner and included within a treatment plan. Family is defined as the primary care-giving unit and is inclusive of the wide diversity of primary caregiving units in our culture. Service components include activities to help the families to develop resources and supports for the benefit of the child/youth, including engagement, bridging and transition, self-advocacy, self-efficacy and empowerment, parent skill development, and community connections. Please reference the Medicaid State Plan Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Testing (EPSDT) Services for definitions of service components and staffing requirements.

Units of Service: Count the number of visits.

4910 - Children & Family Treatment & Support Services: Mobile Crisis Intervention (CI) (Non-Licensed Program)

As a Medicaid funded Children's Health and Behavioral Health Services program, CI services are mobile services provided to children/youth under age 21 who are identified as experiencing acute psychological/emotional change which results in a marked increase in personal distress, and which exceeds the abilities and resources involved to resolve it effectively. CI is a face-to-face intervention that can occur in a variety of settings. CI services are available 24 hours per day, seven days per week and respond within 1 hour of the completion of the initial call to the crisis provider, and upon determination that an in-person contact is required. Services are provided through a multi-disciplinary team to enhance engagement and meet the unique needs of the child/youth and family. The team must be comprised of at least two professionals and one of these two must be a licensed behavioral health professional with crisis intervention service delivery experience. Please reference the Medicaid State Plan Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Testing (EPSDT) Services for specific service components and staffing requirements.

Units of Service: Count the number of visits.

4920 - Children & Family Treatment & Support Services: Youth Peer Support (YPS)

As one of the six Medicaid Funded Children's Health and Behavioral Health Services, YPS services are formal and informal services designed to support youth who are experiencing social, medical, emotional, developmental, substance use, and/or behavioral challenges in their home or community. The service provides the support necessary to encourage engagement and active participation of the youth in the treatment planning process and with the ongoing implementation and reinforcement of skills. The service is delivered by a Credentialed Youth Peer Advocate (CYPA), who must be 18 to 30 years old and has self-identified as a person who has first-hand experience with social, emotional, medical, developmental, substance use, and/or behavioral challenges. The need for this service must be determined by a licensed practitioner and included within a treatment plan. Service components include activities to help the youths to achieve functional improvement, including skill building, coaching, engagement, bridging and transition support, self-advocacy, self-efficacy and empowerment, and community connections and natural support. Please reference the Medicaid State Plan Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Testing (EPSDT) Services for definitions of service components and state requirements.

Units of Service: Count the number of visits.

4930 - Children & Family Treatment & Support Services: Psychosocial Rehabilitation (PSR) (Non-Licensed Program)

As a Medicaid funded Children's Health and Behavioral Health Services program, PSR services are designed to restore, rehabilitate, and support a child's/youth's developmentally appropriate functioning as necessary for the integration of the child/youth as an active and productive member of his/her family and community with the goal of achieving minimal on-going professional intervention. Activities are "hands on" and task oriented, intended to achieve the identified goals or objectives as set forth in the child/youth's individualized treatment plan. Service components include skill development to support personal and community competence, including social and interpersonal skills, daily living skills, and community integration. Please reference the Medicaid State Plan Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Testing (EPSDT) Services for definitions of service components and staffing requirements.

PSR services are to be recommended by a licensed practitioner and as part of a treatment plan. PSR activities are focused on addressing the rehabilitative needs of the child/youth as part of a treatment plan and can be provided in coordination with treatment interventions by a licensed practitioner (e.g., OLP) or provider of community psychiatric support and treatment (CPST).

Units of Service: Count the number of visits.

4940 - Children & Family Treatment & Support Services: Other Licensed Practitioner (OLP) (Non-Licensed Program)

As a Medicaid funded Children's Health and Behavioral Health Services program, OLP consists of three different service components: evaluation, counseling, and crisis. Service components include licensed evaluation (assessment); psychotherapy (counseling); and crisis intervention. OLP is performed by an individual who is licensed in NYS to diagnose, and/or treat individuals with a physical illness, mental illness, substance use disorder, or functional limitations at issue, operating within the scope of practice defined in NYS law and in any setting permissible under State law. OLP services can be provided to individuals, families, or groups, and can be provided on-site or off-site. Please reference the Medicaid State Plan Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Testing (EPSDT) Services for definitions of service components and staffing requirements.

Units of Service: Count the number of visits.

4950 - Children & Family Treatment & Support Services: Community Psychiatric Support and Treatment (CPST) (Non-Licensed Program)

As a Medicaid funded Children's Health and Behavioral Health Services program, CPST services are goal-oriented supports and solution-focused interventions intended to address challenges associated with a behavioral health need and to achieve identified goals or objectives from the child's treatment plan. CPST is a face-to-face intervention with the child/youth (required), family/caregiver or other collateral supports. Service components include intensive interventions, crisis avoidance and management, rehabilitative psychoeducation, strengths-based service planning and rehabilitative supports. Please reference the Medicaid State Plan Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Testing (EPSDT) Services for definitions of service components and staffing requirements.

Units of Service: Count the number of visits.