STATE OF DELAWARE

DELAWARE HEALTH
AND SOCIAL SERVICES
DIVISION OF MANAGEMENT SERVICES
1901 N. DuPont Highway
New Castle, DE 19720

REQUEST FOR PROPOSAL NO. PSC0733

FOR

CO-OCCURRING DISORDERS RESIDENTIAL TREATMENT PROGRAM

DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH
1901 N. DUPONT HIGHWAY
NEW CASTLE, DE 19720

DEPOSIT **WAIVED**
PERFORMANCE BOND **WAIVED**

DATE DUE **March 16, 2007**
11:00 A.M. LOCAL TIME

A mandatory pre-bid meeting will be held on Friday, February 9, 2007 at 10:00 AM in Room 301, Main Administration Building, Herman Holloway Campus, 1901 N. Dupont Highway, New Castle, DE 19720 . A tour of the available state-owned facility located at the Governor Bacon Health Center will be held on Friday, February 9, 2007 at 1:00pm. CONTACT DARLENE PLUMMER AT (302) 255-9430 FOR INQUIRIES.

DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF MANAGEMENT SERVICES
PROCUREMENT BRANCH
HERMAN M. HOLLOWAY SR. HEALTH AND SOCIAL SERVICES CAMPUS
1901 N. DUPONT HIGHWAY
NEW CASTLE, DELAWARE 19720

REQUEST FOR PROPOSAL #PSC0733

Sealed proposals for the Co-Occurring Disorders Residential Treatment Program for the Division of Substance Abuse and Mental Health 1901 N. DuPont Highway, Herman M Holloway Campus, New Castle, DE 19720, will be received by the Delaware Health and Social Services, Procurement Branch, Main Administration Building, Second Floor, Room #259, (South Loop), 1901North DuPont Highway, Herman M. Holloway Sr. Health and Social Services Campus, New Castle, Delaware 19720, until 11:00 A.M. local time, on March 16, 2007, at which time they will be opened, read and recorded. For further information concerning this RFP, please contact Darlene Plummer **(302) 255-9430**. A mandatory pre-bid meeting will be held at 10:00 AM ON February 9, 2007 in Room 301, Main Administration Building, Herman Holloway Campus, 1901 N. Dupont Highway, New Castle, DE 19720. A brief "Letter of Interest" must be submitted with your proposal. Specifications and Administration Procedures may be obtained at the above office, Phone (302) 255-9290.

NOTE TO VENDORS: Your proposal **must be signed** and all information on the signature page completed.

If you do not intend to submit a bid and you wish to be kept on our mailing list you are required to return the face sheet with **"NO BID"** stated on the front with your **company's Name, address and signature.**

IMPORTANT: ALL PROPOSALS MUST HAVE OUR SEVEN-DIGIT PSC# NUMBER ON THE OUTSIDE ENVELOPE. IF THIS NUMBER IS OMITTED YOUR PROPOSAL WILL IMMEDIATELY BE REJECTED.

FOR FURTHER BIDDING INFORMATION PLEASE CONTACT:

SANDRA SKELLEY
DELAWARE HEALTH AND SOCIAL SERVICES
PROCUREMENT BRANCH
1901 NORTH DUPONT HIGHWAY
HERMAN M. HOLLOWAY SR. HEALTH AND
SOCIAL SERVICES CAMPUS
NEW CASTLE, DELAWARE 19720
PHONE: (302) 255-9290

This contract resulting from this RFP shall be valid for the period of time as stated in the contract. There will be a ninety (90) day period during which the agency may extend the contract period for renewal if needed.

If a bidder wishes to request a debriefing, they must submit a formal letter to the Procurement Administrator, Delaware Health and Social Services, Main Administration Building, Second Floor, (South Loop), 1901 North DuPont Highway, Herman M. Holloway Sr., Health and Social Services Campus, New Castle, Delaware 19720, within ten (10) days after receipt of "Notice of Award". The letter must specify reasons for request.

IMPORTANT: DELIVERY INSTRUCTIONS

IT IS THE RESPONSIBILITY OF THE BIDDER TO ENSURE THAT THE PROPOSAL HAS BEEN RECEIVED BY THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES BY THE DEADLINE.

DELAWARE HEALTH AND SOCIAL SERVICES
REQUEST FOR PROPOSAL

CERTIFICATION SHEET

As the official representative for the proposer, I certify on behalf of the agency that:

a. They are a regular dealer in the services being procured.
b. They have the ability to fulfill all requirements specified for development within this RFP.
c. They have independently determined their prices.
d. They are accurately representing their type of business and affiliations.
e. They will secure a Delaware Business License.
f. They have acknowledged that no contingency fees have been paid to obtain award of this contract.
g. The Prices in this offer have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other contractor or with any competitor;
h. Unless otherwise required by Law, the prices which have been quoted in this offer have not been knowingly disclosed by the contractor and prior to the award in the case of a negotiated procurement, directly or indirectly to any other contractor or to any competitor; and
i. No attempt has been made or will be made by the contractor in part to other persons or firm to submit or not to submit an offer for the purpose of restricting competition.
j. They have not employed or retained any company or person (other than a full-time bona fide employee working solely for the contractor) to solicit or secure this contract, and they have not paid or agreed to pay any company or person (other than a full-time bona fide employee working solely for the contractor) any fee, commission percentage or brokerage fee contingent upon or resulting from the award of this contract.
k. They (check one) operate ___an individual; _____a Partnership ____a non-profit (501 C-3) organization; _____a not-for-profit organization; or _____for Profit Corporation, incorporated under the laws of the State of Del.
l. The referenced offerer has neither directly or indirectly entered into any agreement, participated in any collusion or otherwise taken any action in restraint of free competitive bidding in connection with this bid submitted this date to Delaware Health and Social Services.
m. The referenced bidder agrees that the signed delivery of this bid represents the bidder's acceptance of the terms and conditions of this invitation to bid including all specifications and special provisions.

n. They (check one): _____are; _____are not owned or controlled by a parent company. If owned or controlled by a parent company, enter name and address of parent company:

_____
_____
_____
_____

Violations and Penalties:

Each contract entered into by an agency for professional services shall contain a prohibition against contingency fees as follows:

1. The firm offering professional services swears that it has not employed or retained any company or person working primarily for the firm offering professional services, to solicit or secure this agreement by improperly influencing the agency or any of its employees in the professional service procurement process.
2. The firm offering the professional services has not paid or agreed to pay any person, company, corporation, individual or firm other than a bona fide employee working primarily for the firm offering professional services, any fee, commission, percentage, gift, or any other consideration contingent upon or resulting from the award or making of this agreement; and
3. For the violation of this provision, the agency shall have the right to terminate the agreement without liability and at its discretion, to deduct from the contract price, or otherwise recover the full amount of such fee, commission, percentage, gift or consideration.

The following conditions are understood and agreed to:

a. No charges, other than those specified in the cost proposal, are to be levied upon the State as a result of a contract.

b. The State will have exclusive ownership of all products of this contract unless mutually agreed to in writing at the time a binding contract is executed.

_____ _____

Date Signature & Title of Official Representative

_____

Type Name of Official Representative

Notification to Bidders

"Bidder shall list all contracts awarded to it or its predecessor firm(s) by the State of Delaware; during the last three years, by State Department, Division, Contact Person (with address/phone number), period of performance and amount. The Evaluation/Selection Review Committee will consider these additional references and may contact each of these sources. Information regarding bidder performance gathered from these sources may be included in the Committee's deliberations and factored in the final scoring of the bid. Failure to list any contract as required by this paragraph may be grounds for immediate rejection of the bid."

OFFICE OF MINORITY AND WOMEN BUSINESS ENTERPRISE SELF-CERTIFICATION FORM
IF YOUR FIRM WISHES TO BE CONSIDERED FOR ONE OF THE CLASSIFICATIONS LISTED BELOW, THIS PAGE MUST BE SIGNED, NOTARIZED AND RETURNED WITH YOUR PROPOSAL.

_____

COMPANY NAME-
_____

NAME OF AUTHORIZED REPRESENTATIVE (Please print)
_____

SIGNATURE_____

COMPANY
ADDRESS_____
TELEPHONE #_____-
_____

FAX
#_____
EMAIL
ADDRESS_____
FEDERAL EI#
_____

STATE OF DE BUSINESS
LIC#_____

Note: Signature of the authorized representative must be of an individual who legally may enter his/her organization into a formal contract with the State of Delaware, Delaware Health and Social Services.

Organization Classifications (Please circle)
Women Business Enterprise (WBE) Yes/No
Minority Business Enterprise (MBE) Yes/No
Disadvantaged Business Enterprise (DBE) Yes/No
PLEASE CHECK ONE---CORPORATION _____ PARTNERSHIP_____INDIVIDUAL _____

For appropriate certification (WBE), (MBE), (DBE) please apply to Office of Minority & Women Business Enterprise Phone #' (302) 739-4206 (L. Jay Burks)
Fax# (302) 739-5661 Certification #_____ Certifying Agency_____

http://www.state.de.us/omwbe

SWORN TO AND SUBSCRIBED BEFORE ME THIS _____DAY OF _____20_____

NOTARY PUBLIC_____MY COMMISION EXPIRES _____

CITY OF _____COUNTY OF _____STATE OF_____

Definitions

The following definitions are from the State Office of Minority and Women Business Enterprise.

Women Owned Business Enterprise (WBE):
At least 51% is owned by a women, or in the case of a publicly owned enterprise, a business enterprise in which at least 51% of the voting stock is owned by women; or any business enterprise that is approved or certified as such for purposes of participation in contracts subject to women-owned business enterprise requirements involving federal programs and federal funds.

Minority Business Enterprise (MBE):
At least 51% is owned by minority group members; or in the case of a publicly owned enterprise, a business enterprise in which at least 51% of the voting stock is owned by minority group members; or any business enterprise that is approved or certified as such for purposes of participation in contracts subjects to minority business enterprises requirements involving federal programs and federal funds.

Disadvantaged Business Enterprise (DBE):
Any corporation, partnership, sole proprietorship, individual or other business enterprise, operating a business for profit with 100 employees or fewer, including employees employed in any subsidiary or affiliated corporation which otherwise meets the requirements of the federal small business innovation research program, except for the limitation on regarding a maximum number of company employees."

Corporation:

An artificial legal entity treated as an individual, having rights and liabilities distinct from those of the persons of its members, and vested with the capacity to transact business, within the limits of the powers granted by law to the entity.

Partnership:
An agreement under which two or more persons agree to carry on a business, sharing in the profit or losses, but each liable for losses to the extent of his or her personal assets.

Individual:
Self-explanatory

For Certification in one of above bidder must contract:
L. Jay Burks
OFFICE OF MINORITY AND WOMEN BUSINESS ENTERPRISE
(302) 739-4206
Fax (302) 739-5661

REQUEST FOR PROPOSALS (No. PSC-0733)

Co-Occurring Disorders Residential Treatment Program

Division of Substance Abuse and Mental Health

A <u>MANDATORY</u> pre-bid meeting will be held on February 9, 2007 at 10am in Room 301, Main Administration Building, Herman Holloway Campus, 1901 N Dupont Highway, New Castle, DE 19720

A tour of the available state-owned facility located at Governor Bacon Health Center will be held on February 9, 2007 at 1:00pm

BRIEF LETTERS OF INTEREST MUST BE SUBMITTED
AT THE PRE-BID MEETING

STATE OF DELAWARE
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH
1901 North DuPont Highway
New Castle, Delaware 19720

Issued: January 29, 2007

The issuance of this Request for Proposals (RFP) neither commits the Delaware Department of Health and Social Services, Division of Substance Abuse and Mental Health, to award a contract, to pay any costs incurred in the preparation of a proposal or subsequent negotiations, nor to procure or contract for the proposed services. The Division reserves the right to reject or accept any or all proposals or portion thereof, to cancel in part or in its entirety this Request for Proposals, or to delay implementation of any contract which may result, as may be necessary to meet the Department's funding limitations and processing constraints. The Department and Division reserve the right to terminate any contractual agreement without prior notice in the event that the State determines that State or Federal funds are no longer available to continue the contract.

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3) Program Proposal Budget Guidelines……72

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5) LOCUS – Level of Care Utilization System for Psychiatric and Addiction Services, Adult Version 2000……106

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I. ORGANIZATIONAL SYSTEM OVERVIEW

Delaware Health and Social Services (DHSS), created in 1970, is the largest single state agency in Delaware. The Secretary of Health and Social Services directs and integrates the activities of 11 separate divisions/units. All of the state agencies providing institution-based care and community support services to adults with psychiatric disabilities other than Division of Vocational Rehabilitation, the Department of Education and the Department of Correction are under the purview of the Secretary. Divisions included within the Department are: Substance Abuse and Mental Health; Child Support Enforcement; Management Services; Developmental Disabilities Services; Public Health; Services for Aging and Adults with Physical Disabilities; Social Services; State Service Centers; Visually Impaired, Office of the Medical Examiner and Long-Term Care Residents Protection.

Responsibility for Delaware's public mental health services is divided between two cabinet level agencies: Delaware Health and Social Services/Division of Substance Abuse and Mental Health, for persons 18 years old and older, and the Department of Services for Children, Youth and Their Families/Division of Child Mental Health Services, for persons under the age of 18 years. Coordination between the two departments is accomplished through the Governor's Cabinet, direct communication between the Secretaries and Division Directors, and ongoing liaison between staff of the Divisions of Substance Abuse and Mental Health and Child Mental Health Services. There are no city or county funded public human services.

The Division of Substance Abuse and Mental Health (DSAMH, the Division) is responsible the Single State Agency for Mental Health and Substance Abuse services. As such, the Division receives Federal and State dollars for the sole purpose of administering mental health, substance abuse and gambling prevention and treatment services in Delaware.

Central Office. Administration of statewide substance abuse services and mental health services for adults 18 years of age and older is the function of the Central Office. The Central Office has the following responsibilities: implementing Delaware Health and Social Services policy; setting mission, values, and policy within the Division; planning and allocating resources and developing services; managing state and federal inter-governmental relations; managing the delivery system; and managing the flow of consumers with serious mental health illness and substance abuse disorders into long term community support programs. The Central Office includes the following sections: Administrative Services (MIS, Fiscal, Quality Improvement); Planning and Program Development; Human Resource Development and Training; Office of the Director/Deputy Director inclusive of the Office of Consumer Affairs. A Director of Substance Abuse Services oversees the substance abuse and gambling service system for the Division.

Delaware Psychiatric Center. The Delaware Psychiatric Center (DPC) is the single state psychiatric hospital. DPC operates two discrete programs: a 200-bed long-term psychiatric hospital, a 42-bed forensic program, and a 39-bed psychiatric nursing facility.

Crisis Services. These include 24/7 crisis intervention services including mobile intervention, crisis phone intervention, collaboration with police and Hospital emergency room staff in managing crisis interventions, etc. The goal of the mobile crisis approach is to assist in ameliorating a psychiatric crisis.

Substance Abuse Services. The Division operates, directly or through contracts with private agencies, primary prevention and treatment services throughout the state. Treatment services include: Outpatient evaluation and counseling; methadone maintenance; case management services, including intensive multi-disciplinary teams; short and long term residential programs; and residential detoxification services. The Treatment Access Center (TASC), providing targeted services and liaison with the Courts and criminal justice system; and services directed toward problem/compulsive gambling.

Community Support Program Structure For Adults

Over the last thirteen years, DSAMH focused on developing a statewide system of community support programs (CSPs) dedicated to meeting the multiple needs of adults with severe and persistent mental illness. All programs are designed to serve approximately 100 consumers. In many cases, one agency operates more than one community support program. However, each community support program operates with a high degree of resource control and clinical autonomy. Services are delivered via a team approach referred to as *Continuous Treatment Teams (CTT)*. The CTTs are based on the Program of Assertive Community Treatment model. As of January 1, 2002, there were 12 CTT programs operating in the State.

Four *Community Mental Health Clinics*, located in Wilmington, Newark, Dover and Georgetown, provide outpatient mental health treatment services throughout the state. Services include: short-term counseling; psychiatric and supportive counseling; crisis intervention; limited case management; and medication administration and monitoring.

There are three *day programs* operating in Delaware. One program, serving consumers in New Castle County and two programs serving consumers in Kent and Sussex Counties, provide facility-based rehabilitative services in a group format.

Twenty-four hour supervised residences (group homes) are organized as self-contained programs. There are fourteen 24-hour supervised group residences (ten in New Castle County, one in Kent County and three in Sussex County), each ranging in capacity from seven to ten residents. Four of the group homes, referred to as the Meadows program, are located in buildings on a DHSS campus in southern New Castle County. The Meadows program is specifically designed to serve consumers, 55 years of age and older.

II BACKGROUND

The goal of the **COD Residential Treatment Program** is to provide a safe, supportive and therapeutic residential treatment program for adults with co-occurring severe and persistent mental conditions and substance use disorders. The target population generally will have, in addition to their chronic mental health and substance abuse conditions, significant rehabilitative and support needs, including building and maintaining relationships, skills building, employment, housing, transportation, education, etc. The goal of the program is to assist individuals in their recovery process to a more independent, constructive and healthy life.

Objectives

To provide residential treatment appropriate to the needs of individuals in the target population, with the focus on supporting the individual's recovery.

To promote wellness by focusing on all the health needs of the individuals and supporting a healthier lifestyle.

To promote positive social relationships among the program clientele and their friends and family in the community.

A. GUIDING PRINCIPLES

DSAMH subscribes to the following principles of community-based services:

1. Rehabilitation and recovery are possible and a viable goal.
2. Treatment will be readily available with an emphasis on engagement in a therapeutic relationship.
3. Consumers are "managing partners" in their own recovery.
4. No single treatment is appropriate for all individuals: consumers are supported in accessing more or less service as needed.
5. Composition of the treatment team is based on individual needs and can vary over time.
6. Effective treatment attends to multiple needs of the individual including psychosocial, employment, housing, educational and medical needs.
7. An individual's treatment plan must be assessed continually and modified as necessary to ensure that the plan meets the individual's changing needs.
8. Treatment for individuals with mental illness and co-existing substance abuse disorders must be integrated.
9. Possible substance use during treatment must be monitored and addressed on an on-going basis.

10. Community integration is an essential component of all services

DSAMH will require the providers of the ***Co-Occurring Disorders Residential Treatment Program*** to subscribe to these basic principles as demonstrated in their program design, system flexibility and service integration

III. Applicant Organization Eligibility

Applicant organizations/agencies must be non-profit organizations that can document a minimum of five years successful experience in operating an array of services addressing co-occurring disorders, substance abuse and mental health services. Applicants currently must be CARF, NCQA or JCAHO accredited or demonstrate the capability to become accredited within the first two contract years. Documentation must be provided that both the applicant organization and the lead management staff for the proposed program have expertise in the design, implementation and operation of a residential treatment program for co-occurring disorders.

Any applicant organization that cannot demonstrate its ability to meet these eligibility criteria will not be considered for review.

IV. TARGET POPULATION

The program will serve individuals age 18 years and older, with co-occurring mental health and substance use conditions that are uninsured or underinsured:

The target population includes:

- Individuals who are 18 years of age and over;
- Who have a diagnosis of one of the following categories of mental illness as defined in the DSAM-IV-TR:

  Schizophrenic Disorders (295.1, 295.2, 295.3, 295.6, 295.9)
  Delusional Disorders (297.10)
  Psychotic Disorders (295.7)
  Mood Disorders
  - Depressive Disorders (296.32, 296.33, 296.34)
  - Bipolar Disorders (296.4, 296.5, 296.6, 296.7)
  - Personality Disorders
  - Schizotypal Personality Disorders (301.22)
  - Borderline Personality Disorders (301.83)

And

- An ASAM Level of Care of "Clinically Managed Medium-Intensity Residential Treatment" or Clinically Managed High-Intensity Residential treatment"

- A LOCUS Level of Care of 3 or higher.

Adults with DD/MR, in addition to an allowable severe and persistent mental illness diagnosis, must be in the upper mild range (317.0) to be considered for a determination of SPMI provided that the mental health diagnosis is primary. Other individuals with DD/MR diagnoses (318.0, 318.1, 319.0) are ineligible.

Eligibility and ongoing re-determination of eligibility for this program will be managed through the DSAMH Eligibility and Enrollment Unit (EEU). The EEU will manage the program wait list, if any, as well.

Initial length of stay authorization for program services will be for **four months.**

V. SCOPE OF SERVICES

The COD Residential Treatment Program **must, at a minimum, meet the following service requirements:**

1) Provide a safe, therapeutic and homelike residential program for a minimum of 15 individuals with an average length of stay of 4 – 6 months.
2) Provide adequate 24-hour on-site staff.
3) Be eligible for and maintain a license as a substance abuse residential treatment facility.
4) Provide an evidence-based service for co-occurring mental health and substance use conditions (cf. http://www.treatment.org/Externals/tips.html).
5) Treatment Services for adult residents should include:
    i. Substance abuse treatment
    ii. Psychiatric services, including depression screening
    iii. Relapse prevention
    iv. Relationship issues
    v. Family counseling
    vi. Conflict resolution
    vii. Anger management
    viii. Improving parenting skills
    ix. Social skill building
    x. Pre employment skills training
    xi. Life skills training
6) Provide an array of ancillary services including
    i. Medical services
    ii. Housing assistance
    iii. Job search assistance
    iv. Health/nutrition support and education
    v. Parenting training
    vi. NA/AA meetings
    vii. Family support meetings
    viii. Social networking
    ix. Recreation
    x. GED classes

7) Assist residents in accessing entitlements and other appropriate supports in the community, including needed non-psychiatric medical services.

8) Provide case management services to the residents, coordinating the activities and services among the various social service organizations from which they are or will receive supports and services.
9) Develop research based educational programs for residents that foster wellness, positive social skills, self-sufficiency, and recovery.
10) Foster effective transitioning for residents to independent living in the community.
11) Provide services in a culturally sensitive and linguistically appropriate manner.
12) Maximize all appropriate and available resources in developing its budget (e.g. Medicaid, client fees, etc.) and in accessing services for its clientele.
13) Provide a structured opportunity for interdisciplinary educational experiences (externships, research partnership, volunteer supports) with the goal to expose students to the broader community based social service field (medicine, nursing, social work, psychology, etc.)
14) Develop a set of outcome/performance measures by which to gauge its relative success and areas of improvement.

CLIENT FUNDS/ASSISTANCE MANAGEMENT

The Co-Occurring Disorders Residential Treatment Program will be required to safeguard and help manage the personal property and finances of the consumers enrolled in the program.

Appropriate management and utilization of the client assistance monies available from DSAMH must be based on fiscal policies which assure that all other available resources have been accessed prior to the use of these funds. Program staff must be aware of and implement fiscal policy to assure judicious use of limited resources. The program must provide Representative Payee Services as appropriate.

Reimbursement for Client Assistance will be done on a monthly cost-reimbursement request submitted with applicable documentation.

Client assistance funds can be used for the following:

Rental Assistance
Costs respective to assistance for rent for an individual client with specific time frames of the placement/shelter received. Specific destination of payment will be allocated as assistance and/or allocated as a loan to be repaid at a later date. All clients receiving SSDI or SSI payments or in the application stage of entitlement application will receive assistance as a loan with the expectation that repayment can be made at a reasonable payment amount over a period of time acceptable to the budgetary limitations of the client. This will be restricted to assisting residents to transition to community living.

Utilities
Costs associated with all utilities required for the compliance of the provision of decent and safe housing for each individual client after all other allowable community or public resource funding mechanisms have been utilized. Specific designation of payment will be allocated as assistance and/or allocated as a loan to be repaid at a later date. All clients receiving SSDI and/or SSI payments or in the application stage of entitlement application will receive assistance as a loan with the expectation that repayment can be

made at a reasonable payment amount over a period of time acceptable to the budgetary limitations of the client. This will be restricted to assisting residents to transition to community living.

Medical Fees
Fees for client services, by a licensed professional, that are not allowable expenses through other insurance and/or community or public resource funding mechanism. This does not cover services that are covered through the Community Continuum of Care Program (e.g., psychiatrist services, medication management services, etc.)

Dental Fees
Fees for client services, by a licensed professional, that are not allowable expenses through other insurance and/or community or public resource funding mechanism.

Medicine/Medical Supplies
Costs associated with medications, medical supply needs (syringes, hearing aids, bandages, etc) within the boundaries of client services not covered through other insurance or public resource funding mechanism. All providers will be expected to maximize the use of entitlements, scholarship and indigent programs, and client funds to offset the amount of expenses.

Food/Supplies/Other
Costs associated for food, personal care (clothing, hygiene, etc), household supplies and/or other items related to general community living requirements.

VI. AVAILABLE FUNDING

The total available funding for the Co-Occurring Disorders Residential Treatment Program is allocated at a maximum of $775,000 annually. The successful applicant will be expected to collect client fees which will be utilized to offset the expenses of this program prior to the reimbursement of costs by DSAMH.

VII. PROGRAM EVALUATION – PERFORMANCE MEASUREMENT

The successful applicant will work together with DSAMH to establish a data reporting process to monitor and evaluate program performance on both a monthly and on-going basis.

VIII. PROPOSED SCHEDULE OF EVENTS

EVENT	DATE
Publish Request For Proposals	01/29/07
Pre-Submission Meeting (Mandatory)	02/9/07 10:00 am
Building Tour in Delaware City	02/09/07 1:00 pm
Deadlines for Questions	02/16/07 4:30pm
Answers to Questions distributed	02/20/07 4:30pm
Submission Deadline	On or before 11:00am 3/16/07
Notification of Award (estimate)	04/07/07
Sign Contract (estimate)	05/01/07
Service Delivery to begin	07/01/07

IX. MANDATORY PRE-SUBMISSION MEETING

All parties interested in submitting proposals MUST ATTEND the pre-submission meeting, which will be held on February 9, 2007 at 10:00am local time. The meeting will be held in Room 301, Main Administration Building, Herman Holloway Campus, 1901 N. Dupont Highway, New Castle, DE 19720. The purpose of the MANDATORY meeting will be to answer questions regarding solicitation procedures and programmatic issues. Individuals having questions about the meeting should contact Ms. Darlene Plummer, at the Division of Substance Abuse and Mental Health, at (302) 255-9430. No proposals will be accepted by parties other than those attending the mandatory pre-submission meeting.

A tour of the available state-owned facility located at Governor Bacon Health Center will be held on February 9, 2007 at 1:00pm. **NO QUESTIONS WILL BE TAKEN OR ANSWERED DURING THE BUILDING TOUR. ALL FACILITY RELATED QUESTIONS MUST BE SUBMITTED IN WRITING.**

X. SELECTION PROCESS

All proposals submitted, by organizations meeting Applicant Organization Eligibility criteria in response to this RFP will be reviewed by a Proposal Review Team. The Proposal Review Team will evaluate and rate proposals using proposal scoring criteria. Organizations that have submitted proposals receiving a proposal score of 70 or above will be considered qualified to provide the services required by DSAMH. Qualified organizations/proposals will be submitted to the DSAMH Executive Committee and Division Director for final selection. The Division will interview at least one of the qualified firms. The Division may negotiate with one firm without terminating negotiations with another firm and may negotiate with one or more firms during the same period. At any point in the negotiation process, the Division may, at its discretion, terminate negotiations with any or all firms.

XI. PROPOSAL EVALUATION/ RATING

Detailed evaluation/rating criteria will be developed for the review process for this Request for Proposal. Proposals will be rated according to the following general weighted criteria. Questions listed within the criteria are illustrative only. Points will be awarded in each category as indicated. Proposals receiving a score of 70 or above will be considered to meet the minimum qualifications and eligible for final selection as detailed above. Proposals receiving a score less than 70 will not be considered.

1. **Applicant's Experience and Expertise 0-10 points**
   - Does the applicant meet the eligibility criteria?
   - Has the applicant demonstrated successful experience operating programs serving individuals with co-occurring disorders, substance abuse and mental health conditions?
   - Can the applicant meet the licensing requirements as explained in the RFP?
   - Has the applicant documented successful experience in providing services to an SPMI population?
   - How does the applicant propose to meet the accreditation requirements?

2. **Understanding of the Co-Occurring Disorders Residential Treatment Program 0-10 points**
   - How clearly does the applicant demonstrate an understanding of the concept of a Co-Occurring Disorders Residential Treatment Program?
   - How clearly does the applicant define the basic philosophy and theoretical models proposed?
   - Does the applicant cite references for the evidence/research based approaches and models proposed?
   - Are these references from sources with recognized experience and creditability?

3. **Proposed Program Design 0-40 points**
   - Is the model depicted with clarity?
   - Will all of the Core Services be provided directly by the applicant?
   - Does the program design include a methodology to establish individual and organizational outcomes?
   - Does the applicant use evidence based and best practices to address the areas of employment, housing, psychological services, rehabilitative services and medication treatment algorithms?
   - Does the applicant reference the use of LOCUS to determine a consumer's level of care? ASAM?
   - Are all program components and services culturally competent and specific?
   - Does the applicant address client funds/assistance management, including maximizing entitlements and other public funding sources?
   - Will the applicant provide Representative Payee Services?
   - Does the applicant provide for the safeguarding and management of client funds?

- Does the program contain a proposed staffing pattern adequate to perform all of the core elements?
- Does the proposal include a process for ongoing monitoring of fidelity of the evidence based practice?

4. Start-up, Implementation, Transition Plan 0-30

- Does the proposal present a realistic start-up plan?
- Does the proposal contain a chart with realistic timeframes for start-up, transition of clients, other implementation activities?
- Does the proposal contain a detailed transition plan that includes the ability to absorb a significant number of existing clients within a very short time frame?
- Does the plan address issues of assessment, level of care assignment, continuity of care, crisis management?

5. Program Operating Budget 0-10

- Does the budget follow the required formats?
- Is the budget realistic? Does it cover reasonably expected expenses?
- Does the required budget narrative explain expense projections?
- Are management salaries within a reasonable range?
- Are salaries of counselors and other clinical staff within a reasonable range to attract and retain qualified clinicians?
- Is the budget presented for client assistance funds based on maximizing entitlements and other public funding sources? Is it realistic?
- Does the proposal contain a description of representative payee services and client funds management that will assist the consumers in managing their funds? Does the proposal contain a description of the program's plan for charging client fees that is consistent with DHSS policy, and an explanation of the system to be used to determine a client's ability to pay for services?
- Does the applicant have a track record of submitting bills and backup data accurately and on time to DSAMH?
- If proposing a non-state owned facility, is the facility adequate to house this program? Is it a cost –effective alternative?

XII. INVESTIGATION OF PROPOSER'S QUALIFICATIONS

The State of Delaware may make such investigation as it deems necessary to determine the ability of the proposer to furnish the required services, and the proposer shall furnish to the State such data as the State may request for this purpose. The State reserves the right to evaluate the financial and program capability of the proposer to the State's satisfaction. The State reserves the right to reject any offer if the evidence submitted by, or investigation of, such proposer fails to satisfy the State that the proposer is properly qualified to deliver the services requested.

XIII. PROGRAM STANDARDS/CONTRACT MONITORING

Responses to this Request for Proposals will be reviewed primarily for programmatic merit. A satisfactory review does not and will not constitute an approval of the program as having met program standards as required by the Division.

The contractor will be monitored on-site on a regular basis. This monitoring will be based upon the contract and the contractor's proposal. Failure of the contractor to resolve any problem(s) identified in the monitoring may be cause for termination of the contract.

XIV. GENERAL CONDITIONS

1. The proposer must satisfy RFP requirements in the manner described in its proposal as approved by DSAMH. The proposer is required to carry out this project in the manner described in the approved proposal and in accordance with any conditions of the contract. A copy of the Department of Health and Social Services boiler plate contract is included as Attachment 3 to this document. The contract may be suspended or terminated, and future eligibility for services contracts may be lost, should the proposer fail to carry out this project as described in the approved proposal and in the resulting contract.

2. Proposers must meet the minimum requirements set forth in this RFP. They may choose to offer enhancements which go beyond these requirements. Such enhancements may be considered in the overall evaluation of the proposal, but DSAMH/DHSS may reject enhancements/exceptions which do not conform to state bid law and/or create inequality in the treatment of proposers.

3. The proposer may subcontract for services but **must provide direct service provisions for the core program elements required under this contract.** The proposer must have prior approval from DSAMH on all subcontracts. Any contract with the prime contractor will bind sub- or co-contractors to the prime contractor by the terms, specifications, and standards of this RFP and any subsequent proposals and contracts. All such terms, specifications, and

standards shall preserve and protect the rights of the Division under the RFP, and any with respect to the services to be performed by the sub- or co-contractor, so that the sub- or co-contractor will not prejudice such rights. Nothing in this RFP shall create any contractual relation between any sub- or co-contractor and the Division.

4. The proposer must protect the confidentiality of client information. The proposer must have and follow procedures for protecting client information. If applicable, procedures for protecting client information must meet the standards prescribed by the Confidentiality of Alcoholism and Drug Abuse Patient Records, 42 U.S.C. 290 dd-3 and U.S.C. 290 ee-3.

5. The proposer must maintain such records and record systems as are necessary to document and monitor services per DSAMH requirements. The proposer's records must document services provided directly to clients as well as services provided on behalf of clients. Services to clients must be documented in a manner that facilitates the verification of service provision adequate to withstand an audit of claims submitted to the Division.

6. The proposer shall assume the responsibility for providing adequate liability insurance for all service provider personnel (including volunteers or other non-paid personnel), Board of Directors, and/or advisory bodies.

7. The proposer must:

- make reasonable effort to take into account the clientele and the community composition in its personnel hiring and promotion practices;

- make a demonstrative effort, as appropriate, to promote the hiring of minorities and women, and

- encourage minority and client participation on Advisory Councils and the Board of Directors.

8. Where a substantial number of the individuals in the population served by the program are of limited English-speaking ability, the proposer must:

- identify an individual who is fluent both in that language and English and whose responsibilities shall include providing guidance to the individuals of limited English-speaking ability and to appropriate staff members with respect to cultural differences.

9. Accurate property records, inventory control and maintenance for equipment and for all other non-expendable personal property acquired under this program must be maintained. Property records must provide a description of the property, identification number, date of acquisition, cost, present location and/or disposition of property. A physical inventory of non-expendable personal property must be taken and the results reconciled with the property records at least once every two years to verify the existence, current utilization and continued need for the property. A control

system must be in effect to ensure adequate safeguards to prevent property loss. Damage or theft must be investigated and fully documented.

10. Obligation of Contract Funds - Funds authorized for use under the contract may only be obligated within the budget period for which they are awarded. Obligating documents such as a contract and purchase order must be issued on or before the expiration date of the budget period or the funds will no longer be available for use by the contractor. Any contract(s) developed will be for a one-year period. However, the contract(s) will be eligible for annual contract renewals for at least two additional years pending agreement by both parties, satisfactory contractor performance, and funding availability. The Division reserves the right not to renew any contract and, according to the terms of the contract, to terminate any contract.

11. Contract monitoring/corporate audits - A fiscal and programmatic monitoring of the contract may be conducted by the State Agency, usually once a year. Fiscal monitoring shall be conducted in accordance with generally accepted auditing standards. Any Division-initiated contract monitoring, shall neither obviate the need for, nor restrict the contractor from, conducting required annual corporate audits. Annual corporate audits must be conducted in accordance with generally accepted accounting principles and, if applicable, comply with the requirements of the Federal Office of Management and Budget (OMB) Circular A-133.

12. Data - The contractor must furnish contract-related data in accordance with the requirements of DSAMH's management information system (MIS).

13. Notwithstanding anything to the contrary, the Division and Department reserve the right to:

- Select for contract or for negotiations a proposal other than that with the lowest cost;
- Reject any and all proposals received in response to this RFP;
- Waive or modify any information, irregularity, or inconsistency in proposals received;
- Request modification to proposals from any or all proposers during the review and negotiation period;
- Negotiate as to any aspect of the proposal with any proposer and negotiate with more than one proposer at the same time;
- If negotiations fail to result in an agreement within two (2) weeks, terminate negotiations and select the next most responsive proposer, prepare and release a new RFP, or take such other action as the Division and Department may deem appropriate.
- Require proposers to secure a Delaware Business License.
- To contract with more then one provider.

XV. GENERAL INSTRUCTIONS FOR SUBMISSION OF PROPOSALS

1. Number of Copies Required - Two (2) signed originals and ten (10) copies of the proposal and the certification sheets shall be sent to:

   Ms. Sandra Skelley, CPPO
   Department of Health and Social Services
   Division of Management Services, Procurement Branch
   Herman M. Holloway Sr. Health and Social Services Campus
   1901 North DuPont Highway
   Administration Bldg., 2nd Floor, Rm. 259
   New Castle, DE 19720

   THE ORIGINAL (S) (REQUIRED SIGNATURE PAGES IN INK) MUST BE CLEARLY IDENTIFIED BY THE WORDS "ORIGINAL COPY" ON THE OUTSIDE COVER.

   The proposals must clearly indicate that they are in response to RFP number **PSC – 0733.**

2. Closing Date - All responses to this RFP must be received on or before 11:00 A.M. (local time), on March 16, 2007. Delivery is the sole responsibility of the proposer. Proposals are to be delivered or sent to the agency contact at the address specified above. Proposals submitted by mail shall be sent by either certified or registered mail. No late proposals will be accepted. No individual exception to this deadline will be granted. Any proposal received after the specified date and time shall not be considered and shall be returned unopened. The proposing firm bears the risk of delays in delivery. The Division reserves the right to extend the time and place for the opening of bids/proposals from that described above, of not less than five calendar days. Notice by certified mail to those Proposers who obtained copies of the RFP document.

3. Notification of Award - Notification of the award will be made in writing to all proposers by approximately April 5, 2007.

4. Questions – All questions concerning this request for proposals must be directed to Ms. Darlene Plummer, at (302)-255-9430. From the issue date of this RFP until a determination is made regarding the selection of a proposal, all contacts with personnel of the Division of Substance Abuse and Mental Health and other agencies in the Department of Health and Social Services must be cleared through the agency contact.

5. Proposals Become State Property - All proposals become the property of the State of Delaware, and will not be returned to the proposer. All proposers should be aware that government solicitations and the responses thereto are in the public domain. Parts of the proposal, which the proposer considers to be proprietary, should be clearly marked as such. Such requests will be evaluated under the provisions of 29 Del. C. Chapter 100, but shall not be binding on the Department to prevent disclosure of such information. Final discretion on releasing materials rests with DHSS.

6. Proposal and Final Contract - The contents of each proposal will be considered binding on the proposer and subject to subsequent contract confirmation if selected. The content of the successful proposal and the RFP will be incorporated into any resulting final contract. All prices, terms, and conditions contained in the proposal shall remain fixed and valid for ninety (90) days after the proposal due date.

   If the proposer is unwilling to comply with any of the requirements, terms, or conditions of the RFP, objections must be clearly stated in the proposal. Objections will be considered and may be subject to negotiation at the discretion of the State.

7. Amendments to Proposals - Amendments to proposals will not be accepted after the receipt deadline for proposals is passed, unless requested by the Division in writing. The State reserves the right at any time to request clarifications and/or further technical information from any or all proposers submitting proposals.

8. Pre-Contract Costs - All pre-contract activities or costs incurred by proposers in the preparation of their proposals, or during any negotiations on proposals or proposed contracts, or for any work performed in connection therewith, shall be borne by the proposer.

9. Contractor's Equipment - The State of Delaware will not be responsible for the contractor's equipment due to loss, theft, or destruction.

10. Funding Disclaimer Clause - The Department reserves the right to reject or accept any bid or portions thereof, as may be necessary to meet the Department's funding limitations and processing constraints. The Department reserves the right to terminate any contractual agreement without prior notice in the event that the state determines that state or federal funds are no longer available to continue the contract.

11. Contract Termination Clause - The Department may terminate the contract resulting from this request at any time that the contractor fails to carry out the provisions or to make substantial progress under the terms specified in this request and the resulting proposal.

    The Department shall provide the contractor with thirty (30) days notice of conditions endangering performance. If after such notice the contractor fails to remedy the conditions contained in the notice, the Department shall issue the contractor an order to stop work immediately and to deliver all work and all work in progress to the state. The Department shall be obligated only for those services rendered and accepted prior to the date of notice of termination.

Upon receipt of no less than thirty (30) days written notice, OR in accordance with contract provisions, the contract may be terminated on a date prior to the end of the contract period without penalty to either party.

12. Fees – It is a State policy that clients should pay all or part of the costs of Services received if they are financially able to do so. The contractor would be expected to continue this policy.

13. Debriefing - If a proposing firm wishes to request a debriefing for technical assistance purposes, the proposing firm shall submit a formal letter to the Contracts Manager, Division of Substance Abuse and Mental Health, First Floor, Main Administration Building,, 1901 N. DuPont Highway, Herman M. Holloway Sr. Health and Social Services Campus, New Castle, DE 19720, within 10 days after receipt of a letter informing the proposing firm of the outcome of the review and evaluation process. This letter shall specify reason(s) for the request.

XVI. PROPOSAL ORGANIZATION

The Proposal submitted in response to this request must conform to the format described in these instructions. The application should contain a cover letter that includes names and titles of key personnel to contact for additional application information. The cover letter will be considered an integral part of the proposal.

The cover letter must be followed by the completed Checklist (Form A). All pages must be numbered consecutively.

Each proposer is required to submit the Technical Proposal and Business Proposal as separate sections. The Business Proposal should address the cost of performing the work described in the Technical Proposal. The proposer shall not make any reference to costs in the Technical Proposal. In preparing a response, the proposer should follow the format as outlined in the checklist (Form A) and include the checklist with the proposal, as specified. Failure to follow the format could result in disqualification of the proposal.

The proposer may be requested to submit a complete independent audit and analysis of financial condition, covering the most recent fiscal year, during the review process, and, if selected, will be required to submit this material.

XVII. REQUIRED SIGNATURE FORMS

A. Bidders Signature Form (Form H)
B. Contractor Representation, Certification and Acknowledgement Form (Form C)
C. Statement of Compliance Form (Form G)
D. Non-Collusion Statement (Form H)

XVIII. TECHNICAL PROPOSAL REQUIREMENTS

a. **Co-Occurring Disorders Residential Treatment Program**

1. **Program Abstract** – Describe the residential treatment program based on Evidence Based Practices. Describe the corporate or program readiness to implement the proposed evidence based practices including the resources, infrastructure and experienced staff that are in place or will be put in place to support implementation. Describe the process to monitor and ensure fidelity to the evidence based practice.

2. **Geographic Area(s)** – The applicant must identify the facility option being proposed. If selecting Option A (non-state owned facility), the specific site should be described (address, description of building and facilities to be used for the program, etc.).

3. **Scope of Services:** This section must describe in detail how the program will meet all requirements, including:

   - Specific evidence/research based documentation to support the program design and treatment approach(es) to be used.
   - Description of how the program will provide all the Core Elements.

Core Program Elements:

- Provide a safe, therapeutic and homelike residential program for a minimum of 15 individuals with an average length of stay of 4 – 6 months.
- Provide adequate 24-hour on-site staff.
- Be eligible for and maintain a license as a substance abuse residential treatment facility.
- Provide an evidence-based service for co-occurring mental health and substance use conditions (cf. http://www.treatment.org/Externals/tips.html).
- Treatment Services for adult residents should include:
    - Substance abuse treatment
    - Psychiatric services, including depression screening
    - Relapse prevention
    - Relationship issues
    - Family counseling
    - Conflict resolution
    - Anger management
    - Improving parenting skills

    - Social skill building
    - Pre employment skills training
    - Life skills training
- Provide an array of ancillary services including
    - Medical services
    - Housing assistance
    - Job search assistance
    - Health/nutrition support and education
    - Parenting training
    - NA/AA meetings
    - Family support meetings
    - Social networking
    - Recreation
    - GED classes

- Assist residents in accessing entitlements and other appropriate supports in the community, including needed non-psychiatric medical services.
- Provide case management services to the residents, coordinating the activities and services among the various social service organizations from which they are or will receive supports and services.
- Develop research based educational programs for residents that foster wellness, positive social skills, self-sufficiency, and recovery.
- Foster effective transitioning for residents to independent living in the community.
- The program is to provide services in a culturally sensitive and linguistically appropriate manner.
- The program must maximize all appropriate and available resources in developing its budget (e.g. Medicaid, client fees, etc.) and in accessing services for its clientele.
- The program must provide a structured opportunity for interdisciplinary educational experiences (externships, research partnership, volunteer supports) with the goal to expose students to the broader community based social service field (medicine, nursing, social work, psychology, etc.)
- The program will develop a set of outcome/performance measures by which to gauge its relative success and areas of improvement.

CLIENT FUNDS/ASSISTANCE MANAGEMENT

Describe the program's policies and procedures on the safeguarding and managing the personal property and finances of the consumers enrolled in the program.

Describe the program's fiscal policy and procedures on the utilization of client assistance funds.

Describe the program's ability to provide and experience in providing Representative Payee Services.

Describe how the program will assure that staff understand the fiscal policies and procedures on the utilization of client assistance funds.

Describe how the program will monitor staffs' utilization of client assistance funds.

Describe the program's internal control policy and procedure relating the use and disbursement of these funds.

4. Staffing and Staff Qualifications – Organization charts must be included that depict: (a) where the Co-Occurring Disorders Residential Treatment Program will fit into the overall organization structure; (b) all components and staff of the Co-Occurring Disorders Residential Treatment Program. The proposal must address how the proposed staff will meet licensing standards.

The proposer must present a complete staffing pattern with job descriptions for key managerial and supervisory clinical positions. The staffing pattern must indicate if the position is full or part-time. If part time, it must indicate the number of hours per week. The staffing pattern must be predicated upon serving the number of clients specified by the applicant of this RFP. The job descriptions must include the minimal educational, experiential and credentialing requirements for each position, along with a description of the duties of the position. .

In developing the staffing pattern, applicants should refer to the DSAMH Licensing Standards, and the Core Elements Section of this RFP to assure that job descriptions meet required qualifications. Clinical supervisors will be required to enroll in the Clinical Supervision Project sponsored by the DSAMH Training Office.

The proposer must provide:

a. Job Descriptions

There must be a complete job description for all positions that have been included in all or part of the cost of this proposal. Each description should contain:

1) Position title: This should be the same title as used in the budget, and as shown in the sections on program description, and organization charts.
2) Salary range: Please state the yearly and/or hourly range.
3) Job summary: This should describe the role of the position in the proposed program and identify the lines of authority related to this position.
4) Duties and responsibilities: List the major activities of the person in this position.
5) Job qualifications: The minimum education and/or experience requirements should be presented.

b. Resumes of Key Staff

Resumes of key staff for the proposed program, if known to the proposer at the time of response to the RFP, must be included.

c. Screening and Hiring Procedures

The proposer must provide guidelines to be used in staff screening and hiring procedures. Measures adequate to screen job applicants to determine history of patient/client abuse/neglect (must comply with 29 Del. C. Section 708 and 11 Del. C. Section 8564) must be described.

d. Staff Training/Orientation and Development

A staff training and/or orientation plan applicable to all staff who will be assigned to the program must be presented. The plan/schedule should include:

1) introductory training and orientation schedule;
2) mandatory training on Department of Health and Social Services Policy Memorandum 46;
3) mandatory training on confidentiality of client information

e. Staff Schedule

The proposer must provide:

1) A complete program staffing roster that clearly presents the full staffing complement for the proposed program. Each position must be listed by position title and the full time equivalent status of that position (e.g.: 1.0 FTE, 0.5.FTE, etc.).

.

2) A full one-month staff schedule that clearly presents the proposed staffing patterns for the program.

The proposer should assure that the program staffing roster and the full staff schedule are reconciled with respect to the number of FTE positions required AND that all positions are accounted for in the business proposal.

The proposer must specify the minimum staff to resident ratio which will be provided (specify times during which minimum staffing will prevail).

g. On-call/Back-up Staffing

The proposer must describe its provisions for on-call or back-up staffing (including minimum qualifications of on-call or back-up staff if different from minimum qualifications of regular program staff).

Subcontractor List
If subcontractors will be used, the following must be provided: 1) identification of the sub-contractor; 2) purpose; 3) tasks to be performed; 4) FTE comparison; and 5) method of compensation.

h. Shared Staff

If the proposed program will utilize staff that will be shared with, or co-assigned to, other programs, the proposer must describe this arrangement and address the effect such staff-sharing or co-assignment will have on the operation of the proposed program.

i. Volunteer Staffing

If volunteer staff are to be used to provide staff coverage for the proposed program, the proposer must clearly describe the role of volunteers and clearly indicate volunteer positions in the staffing chart required in RFP Section XVIII; A. Volunteer staff are subject to the same requirements for qualifications, training, and screening/hiring procedures as paid staff.

5. Accreditation – The applicant must present a timetable for obtaining accreditation from an approved accrediting agency or proof that the program is already accredited. If the organization/agency is already accredited, the applicant should present verifying documentation in the response to the RFP.

6. Implementation Plan –Applicants must submit an Implementation Plan in chart format with timelines for each activity. The plan must cover start up through full program implementation activities. It must describe how this process will be altered/enhanced if the applicant is selected and required to absorb a significant number of clients within a very short period of time. The length of time that the applicant proposes for program start up and to reach full capacity will be important factors in the application rating process.

7. Transition Plan – Describe the transition process by which consumers, current and future, are incorporated into the proposed program model. This plan should address issues of assessment, levels of care assignment, continuity of care (including medication maintenance), crisis management, etc. This plan should describe the transition of individuals who are currently served within the program as well as clients new to the Division's long-term benefit and referred from DSAMH's EEU.

8. Organization Capability and Experience – Applicants for this RFP must provide documentation that they meet the following conditions:

a) A minimum of five years of documented, successful experience operating an array of community based mental health services. Provide evidence that both the applicant organization and the lead management staff for the proposed program have expertise in the design, implementation and operation of a continuum of community based mental health services.

b) Proposer must able to provide assurance as part of this application that the applicant organization has the capability and expertise to obtain licensing in Delaware upon receipt of an award. All applicants will be required to possess or obtain, at a minimum, a provisional DSAMH license to operate a Residential Treatment Program for Substance Abuse prior to opening. Applicants must be currently CARF, NCQA or JCAHO accredited or demonstrate the capability to become accredited within the first two contract years.

[The fact sheet (Form B) must be completed and submitted with the program proposal.]

9.. Statements of Assurance

Proposers must provide written assurance that the following conditions will be met.

A) Availability of IRS Ruling relating to tax exempt status for nonprofit incorporated organizations (as applicable).

B) Availability of Liability Insurance.

C) Availability of Auto Insurance. This is required for all vendors who operate any type of transportation vehicle as part of their program.

D) Civil Rights. Compliance with provisions of Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act, and any other federal or State anti-discriminatory act, law, statute, or regulation.

E) Policy and Procedures Manual. A statement should be included that the proposer shall develop a written manual covering policies and

procedures of the program. A copy of the manual shall be submitted for approval within 45 days from the date of contract award. If the proposer has a current policy and procedures manual which will be used, a statement regarding its availability upon request by the review committee should be submitted with the proposal.

F) Compliance Agreement for Procedure to be Followed to Comply with Policy Memorandum 46. The proposer must include a statement of compliance with the Policy Memorandum (see Attachment 1).

G) Statement of Confidentiality. The proposer should either include the statement of client confidentiality in effect for the applicant organization or prepare and include such a statement to be used for the proposed program.

H) Statement and/or Documentation of Professional Ethical Standards Applied in Organization. The proposer should include the statement of professional standards currently in use by the applicant organization or prepare and include such a statement to be used for the proposed program.

10. References

Each proposer must supply the names of a minimum of three (3) references familiar with the background and qualifications of the proposers and its ability to implement the proposed program. Addresses and phone numbers of the references must be included, as well as a description of the capacity in which the reference knows the proposer.

Notification to Bidders

"Bidder shall list all contracts awarded to it or its predecessor firm(s) by the State of Delaware during the last three years, by State Department, Division, Contact Person (with address/phone number), period of performance and amount. The Evaluation/Selection Review Committee will consider these as additional references and will contact each of these sources. Information regarding bidder performance gathered from these sources may be included in the Committee's deliberations and factored into the final scoring of the bid. Failure to list any contract as required by this paragraph will be grounds for immediate rejection of the bid."

11. Program Facility

OPTION A – NON-STATE OWNED FACILITY

Proposers must provide proof that they already own or have a commitment to purchase or lease of a facility suitable for the proposed program. DSAMH is willing to negotiate the date by which the facility must be ready for occupancy. However, unless there are extraordinary circumstances, the usual expectation is that the site/facility will be ready for occupancy no later than 90-days from inception of contract.

The proposer must identify and describe the facility in which the proposed program will be provided.

At a minimum, the proposer must provide:

a. The address of the proposed facility.

b. A description of the facility, including a floor plan that indicates the location within the facility proposed for use for the proposed program (if co-located with another program).

c. A description of any facility renovations or improvements that will be needed to make the facility suitable for use. First year contract funds may be used for minor renovations and repairs to the facility, and for purchase of necessary equipment/furnishings.

d. Assurances that the proposed facility is suitable for use in the provision of the proposed program and that it will meet all applicable zoning, licensing, life-safety, environmental or other requirements. (NOTE – The facility must meet all such requirements, and the contractor must obtain all required approvals prior to program opening and acceptance of any residents.)

e. Agreement to work in conjunction with DSAMH to notify elected officials, civic and neighborhood associations to assure acceptance and support of the community.

f. If the proposed facility will house other programs or services concurrently with the proposed program (or is anticipated to house such other programs or services), the proposer must describe those programs/services and identify any proposed relationship between such programs/services and the proposed program. Co-located programs/services must be compatible with the needs of the proposed program and present no threat to the health or safety of the residents of the proposed program**.**

OPTION B – STATE OWNED FACILITY

Proposer must indicate that they choose to operate the Co-Occurring Disorders Residential Treatment Program at the state-owned facility located at the Governor Bacon Health Center Campus in Delaware City, Delaware.

XIX. Business Proposal Requirements

The Business Proposals and all budget information must be presented separate from the Technical Proposal.

Each program component requires a separate business proposal with a detailed budget narrative that includes all assumptions made with respect to the pricing of services.

a. Operating Budget

The Division anticipates purchasing Co-Occurring Disorders Residential Treatment program on a cost-reimbursement basis. For the purposes of proposal review, a full year's proposed operating budget is required in this response. If start-up funds are being requested, a separate budget proposal must be submitted indicating specific items that these funds will be utilized for. A detailed budget narrative must also accompany any start up funds request. Using Budget Proposal Form D (or a facsimile thereof) and following the Program Proposal Budget Guidelines presented in Attachment#2, the proposer must present a business proposal in a line-item format. A detailed budget narrative that includes all assumptions made with respect to the pricing of services must also be included.

The operating budget should apply to the budget period beginning July 1, 2007 and ending June 30, 2008.

Costs for client assistance will be paid as part of the monthly cost-reimbursement invoice but will be submitted on a separate form to allow ease of reporting. The attached budget form provides a separate detailed listing of client assistance funds requested as part of the operating budget.

The successful applicant will be required to collect client fees and follow DSAMH and DHSS policies and procedures on the safeguarding and reporting of resident funds. The required budget narrative must specify the methodology and formulas the successful applicant will utilize to collect client fees.

If the applicant is interested in proposing to submit a proposal based on using facility Option A AND Option B – two separate business proposals must be submitted.

Financial Practices Self-Report

The bidder must complete Form F, Financial Practices Self-Report.

FORM A

REVISE AS NECESSARY Checklist

This checklist is provided to aid both the proposer and the reviewer in determining that all necessary information is included in the proposal package. In the blanks next to each item, please denote the page number(s) in the proposal where that information can be found. The completed checklist should be submitted as the first item in the proposal.

Item	Page
REQUIRED SIGNATURE FORMS:	
Bidder's Signature Form (Form G)	
Contractor Certification Sheet (Form C)	
Statement of Compliance (Form E) Non-Collusion Statement (Form H)	
TECHNICAL PROPOSAL	
1. Program Abstract	
2. Geographic Area(s)	
3. Scope of Services	
• Specific evidence/research based documentation	
• Core Program Elements	
4. Staffing and Staff Qualifications	
• Personnel Policies	
• Job Descriptions	
• Resumes of Key Staff	
• Screening and Hiring Procedures	
• Staff Training • Staff Schedule	
• On-Call/Back-up Staffing • Shared Staff	
• Volunteer Staffing	
5. Accreditation	
6. Implementation Plan	
7. Transition Plan	
8. Organization Capability and Experience	
9. Statements of Assurance	
10. References	
• 3 references	
• Listing of all State of DE contracts during last 3 years	
11. Program Facility	

BUSINESS PROPOSALS	
A. Operating Budget for July 1, 2007- June 30, 2008	
Detailed Budget Narrative	
B. Start-up Funds Request (if any)	
Detailed Budget Narrative	
C. Cost-Reimbursement Budget for Client Assistance Funds	
Detailed Budget Narrative	
D. Form F – Financial Practices Self-Report	

FORM B

Fact Sheet

1. Corporate Name

2. Mailing Address

   _____ Zip Code

3. Business Address if different from mailing address

4. Telephone __(____)
   (Area Code)

5. Director's Name _____ Telephone _(___)

6. Name of contact person if other than Director

7. List of names of those with authority to sign contracts
   (name/title/phone)

8. Date of Incorporation

9. If the agency operates from more than one location, please provide the address and phone numbers of the other locations:

10. Delaware Business License No.

11. Federal Employer Identification No.

12. Copy of Corporate Organization Structure (attach)

13. Roster of Corporate Officers (attach)

CONTRACTOR REPRESENTATION, CERTIFICATION AND ACKNOWLEDGMENT

As the official representative for the proposer, I certify on behalf of the proposer that:

A. They are a regular dealer in the services offered.

B. They have the ability to fulfill all the requirements specified for the development and operation of the program within this offer and that their proposal includes all costs necessary for and incidental to their total performance under the contract.

C. They are accurately representing their type of business and affiliations.

D. They will secure a Delaware Business License.

E. 1. The prices in this offer have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other contractor or with any competitor;

2. Unless otherwise required by law, the prices which have been quoted in this offer have not been knowingly disclosed by the contractor and will not knowingly be disclosed by the contractor prior to award in the case of a negotiated procurement, directly or indirectly to any other contractor or to any competitor; and

3. No attempt has been made or will be made by the contractor in induce any other persons or firm to submit or not to submit an offer for the purpose of restricting competition.

F. They have not employed or retained any company or person (other than a full-time bona fide employee working solely for the contractor) to solicit or secure this contract, and they have not paid or agreed to pay any company or person (other than a full-time bona fide employee working solely for the contractor) any fee, commission percentage or brokerage fee contingent upon or resulting from the award of this contract.

G. They operate as (check one): ___ an individual; ___ a partnership, ___ a non-profit (501 C-3) organization; __ a not-for-profit organization, or ___ for-profit corporation, incorporated under the laws of the State of _____.

D. They (check one): ___ are; ___ are not owned or controlled by a parent company. If owned or controlled by a parent company, enter name and address of parent company:

The following conditions are understood and agreed to:

1. No charges, other than those shown in the Business Proposal, are to be levied upon the State as a result of a contract.

2. The State will have exclusive ownership of all products of this contract unless mutually agreed to in writing at the time a binding contract is executed.

Name of Contractor's Authorized Administrato Signature of Authorized Administrator

Name of Company Date

Company Address _____

_____

_____

Company Telephone Number __(____)_____

PSC - 0733

BUDGET PROPOSAL

Provider Name: 1
Contact Person: 2 Telephone: 3
Program Name: 4 Budget Period: 5

Direct Personnel Staff Roster			
Employee Name/Title		TOTAL FTE	23 Annual Costs
6	7	8	
Sub-Total			

PSC - 0733

BUDGET PROPOSAL

Provider Name: 1
Contact Person: 2 Telephone: 3
Program Name: 4 Budget Period: 5

Direct Personnel Staff Roster			
Employee Name/Title	FTE ACT ONLY	TOTAL FTE	23 Annual Costs
6	7	8	
Subtotal			
Total Direct Staff			

	Annual Cost
Fringe Benefits/OEC	
Payroll Tax	
Health Benefits	
Other Fringe Benefits	
Total Fringe/OEC	
TOTAL DIRECT STAFF & FRINGE BENEFIT COSTS	
Staff Travel & Training	
Staff Training	
Staff Mileage	
Staff Public Trans.	
Staff Meals/Clothing	
TOTAL STAFF TRAVEL & TRAINING	
Occupancy Costs	
Real Estate Tax	
License, Permits, Fees	
Utilities	
Repairs/Maintenance	
Rent	
Custodial Supplies	
Insurance	
Other Occupancy Costs	
TOTAL OCCUPANCY COSTS	
Transportation Costs	
Gas & Oil	
Vehicle Repair/Maintenance	
Vehicle Insurance & Taxes	
Vehicle Lease	
Contractual Transportation	
Public Transportation	
Other Transportation Costs	
TOTAL TRANSPORTATION COSTS	
Operating Costs	
Consultant Costs	
Telephone	
Postage	
Advertising/Recruiting	
Printing/Reproduction	
Office Supplies	
Equipment Rental	
Equipment Repair/Maintenance	

Educational Supplies	
Other Operating Costs	
Capital Expenses (attach detail listing)	
TOTAL OPERATING COSTS	
TOTAL DIRECT PROGRAM COSTS	
INDIRECT/AMINISTRATIVE COSTS TOTAL COST	

RFP PSC-0733
Co-Occurring Disorders Residential Treatment Program
CLIENT ASSISTANCE BUSINESS PROPOSAL
FORM E

CLIENT ASSISTANCE CATEGORIES	AMOUNT
Rental Assistance	
Utilities	
Medical Fees	
Dental Fees	
Medicine/Medical supplies	
Food/Personal Care Supplies	
Other Client Assistance	
SUBTOTAL	0

OTHER INCOME APPLIED

TOTAL CLIENT ASSISTANCE BUDGET REQUEST 0

Anticipated sources of other income	Amount
TOTAL	0

F0RM G

STATEMENT OF COMPLIANCE FORM

As the official representative for the contractor, I certify on behalf of the agency that:

_____(Company Name) will comply with all Federal and Delaware laws and regulations pertaining to equal employment opportunity and affirmative action. In addition, compliance will be assured in regard to Federal and Delaware Laws and regulations relating to confidentiality and individual and family privacy in the collection and reporting of data.

Authorized Signature _____

Title _____

Date: _____

FORM F

CONTRACT AGENCY: _____

DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

FINANCIAL PRACTICES
PRE-AUDIT MONITORING SURVEY
SELF-REPORT

1. Do you maintain a **summary of total program funding and a breakdown of approximate funding by source**?

   Yes _____ No _____

   Comments: _____

2. Is your type of accounting system cash [ ] or accrual [ ]?

   Comments: _____

3. Does your **Chart of Accounts** include a description of the accounts, numeric and word components and the topical organization of the accounting system?

   Yes ___ No _____

   Comments: _____

4. Do you maintain the following **accounting records**?
(Check those maintained)

General Ledger	____	Journals	____
Subsidiary Ledgers	____	Checkbooks	____
Payroll Records	____	Bank Statements	____
Paid & Unpaid Invoices	____	Funds Receivable	____
Accounts Payable	____	Time Sheets	____
Supportive Documentation	____	Petty Cash	____
Payroll Registers	____	Proof of Payroll	____
Cancelled Checks	____	Tax Payments	____

Comments: _____

_____

_____

_____

5. What type of **financial statements**, frequency, and distribution of financial statements are maintained by the program? Who reviews and approves financial statements? (List)

Type	**Frequency**	**Distributed by**	Reviewed/ Approved By

(Use additional pages as necessary)

6. Does the program have a person or persons responsible for the preparation and review of the program budget?

Yes _____ No _____ Name _____

Comments: _____

_____

_____

_____

a. What are the procedures for preparing the **overall program budget**? (Summarize)

_____
_____
_____
_____
_____
_____
_____

b. What are the procedures for estimating the projected income? (Summarize)

_____
_____
_____

c. What are the procedures for periodic budget review and adjustments? (Summarize)

_____
_____
_____

7. What are your procedures for: a) receipt of funds (receiving-recording-depositing), b) disbursement of funds (supporting document flow), c) authorizing signatures, and d) check writing procedures? (Summarize)

a. _____
_____
_____

b. _____
_____
_____

c. _____
_____
_____

d. _____
_____
_____
_____
_____
_____

8. What are your procedures for purchasing?

a) Solicitation and bids for service

b) Receipt and inspection of goods (Summarize)

9. What is your procedure for payroll processing?

a. Is the payroll manual [ ] or automated [ ]?

b. What is the payroll period; weekly, monthly, etc.?

Comments: _____

c. Does the **payroll record** include time sheets __, payroll register and employee individual earning records __?

Comments: _____

d. Payroll automation - does it include approval of time sheets __, signature on payroll checks __ and payroll taxes __?

Comments: _____

10. Petty cash procedures:

a. What are the allowable uses of the petty cash fund? (Summarize)

_____

_____

_____

_____

b. Are there standard forms and procedures for using the petty cash fund? (Summarize)

_____

_____

_____

_____

c. What is the maximum balance maintained in petty cash fund?

_____

_____

_____

_____

d. What are the limits on individual transactions?

_____

_____

e. What are the procedures for reconciling and replenishing the petty cash fund? (Summarize)

_____

_____

11. Billing for services:

a. What are the procedures for determining client/consumer fees? (Summarize)

_____

_____

_____

_____

b. Do you maintain a schedule of fees? (Comments)

c. How is the client informed about the fee schedule? (Summarize)

d. How is client ability to pay determined? (Summarize)

e. How is receipt of client fees documented? (Summarize)

f. What are the procedures for billing clients? (Summarize)

g. What are the procedures for billing third-party payers? (Summarize)

h. What are the procedures for handling delinquent accounts? (Summarize)

_____

_____

12. Internal Controls

What are the internal management mechanisms for safeguarding the assets of the organization and for preventing and detecting errors? Do the contractor controls include:

a. Written Fiscal/Financial Practice Policies and Procedures?

Yes ____ No ___

Are these Policies and Procedures regularly reviewed and revised as necessary?

Yes ____ No ____

b. Separation of functional responsibilities?

Yes ____ No ____

Comments:

_____

_____

_____

_____

2 c. Accurate and complete book of accounts?

Comments:

_____

_____

_____

_____

d. Financial reports?

Yes _____ No ____

Comments:

_____

_____

_____

e. Proper documentation?

Yes _____ No ____

Comments:

_____

_____

_____

f. Annual audit?

Yes _____ No ____

Comments:

_____

_____

_____

g. Bonding of employees handling money?

Yes _____ No _____

Comments:

_____

_____

_____

13. Corporation Data:

Do you maintain the **following documents** up to date?

		YES	NO
a.	Fidelity Bond		
b.	Insurance Policies for property Liability Vehicle		
c.	IRS Form 501C – Tax Exempt Status		
d.	IRS Form 4161 – Social Security Waiver		
e.	IRS Form 990 – Organization Exempt from Tax		
f.	IRS Form 941 – Qtly. Rpt. of Federal Withholding		
g.	Delaware Annual Franchise Tax Rpt		
h.	Delaware Unemployment Compensation & Disability Insurance Report		
i.	Delaware Forms (VCE - UC8A) W1-W3 Report of State Withholding		
j.	Contracts for Purchased Services (i.e. Rent, etc.)		
k.	Malpractice/Liability insurance to protect agency/staff against lawsuits brought by recipients of services		
l.	Corporate Documentation (e.g.: Certificate(s) of Incorporation; By-laws; Policy & Procedures; etc.)		
m.	Business license [State(s)]		

14. Property Management:

a. Do you maintain an inventory of furnishings, office equipment, and other capital property?

Yes ____ No ____

Does the inventory show? (check all that apply)

Purchase or acquisition date	
Purchase Price	
Source of funds for purchase	
Identification number of item (serial number, model number, etc.	
Condition of item	
Location of item	
Date of loss, destruction or other disposition of item	

b. Is the inventory kept up-to-date?

Yes _____ No _____
How often is the inventory updated? _____

Who is responsible for keeping the inventory?

_____

15. Indirect/Administrative Cost

a. Does your agency charge an indirect/administrative cost to any of the programs or projects conducted or operated by the agency?

Yes _____ No _____

b. How do you determine the indirect cost pool for the agency? (Briefly summarize)

_____

_____

_____

Does the agency have a written policy on the development/application of indirect/administrative charges?

Yes _____ No _____

16. Survey Completed by _____

Title/Position_____

Signature_____ Date _____

FORM H

Delaware Health

And Social Services

DIVISION OF MANAGEMENT SERVICES

BIDDERS SIGNATURE FORM

NAME OF BIDDER _____

SIGNATURE OF AUTHORIZED PERSON _____

TYPE IN NAME OF AUTHORIZED PERSON: _____

TITLE OF AUTHORIZED PERSON: _____

STREET NAME, AND NUMBER _____

CITY, STATE, AND ZIP CODE: _____

CONTACT PERSON: _____

TELEPHONE NUMBER: _____

FAX NUMBER: _____

DATE:_____

BIDDER'S FEDERAL EMPLOYERS IDENTIFICATION NO:_____

F.O.B.:_____

TERMS:_____

THE FOLLOWING MUST BE COMPLETED BY THE VENDOR:

AS CONSIDERATION FOR THE AWARD AND EXECUTION BY DELAWARE HEALTH AND SOCIAL SERVICES OF THIS CONTRACT, THE (COMPANY NAME)_____ HEREBY GRANTS, CONVEYS, SELLS, ASSIGNS, AND TRANSFERS TO THE STATE OF DELAWARE ALL OF ITS RIGHTS, TITLE, AND INTEREST IN AND TO ALL KNOWN OR UNKNOWN CAUSES OF ACTION IT STATES AND THE STATE OF DELAWARE RELATING THE PATROLLER GOODS OR SERVICES PURCHASES OR ACQUIRED BY THE DELAWARE HEALTH AND SOCIAL SERVICES PURSUANT TO THIS CONTRACT.

NON-COLLUSION STATEMENT & CLASSIFICATIONS FORM
THIS PAGE MUST BE SIGNED, NOTARIZED AND RETURNED WITH YOUR BID PROPOSAL

COMPANY NAME_____
NAME OF AUTHORIZED REPRESENTATIVE (Please print)_____
SIGNATURE_____
COMPANY
ADDRESS_____
TELEPHONE #_____
FAX #_____
EMAIL ADDRESS_____
FEDERAL EI# _____STATE OF DE BUSINESS LIC#_____

Note: Signature of the authorized representative MUST be of an individual who legally may enter his/her organization into a formal contract with the State of Delaware, Delaware Health and Social Services.

This is to certify that the above referenced offer has neither directly nor indirectly entered into any agreement, participated in any collusion or otherwise taken any action in restraint of free competitive bidding in connection with this bid submitted this date to Delaware Health and Social Services.

The above referenced bidder agrees that the signed delivery of this bid represents the bidder's acceptance of the terms and conditions of this invitation to bid including all specifications and special provisions

---

Organization Classifications (Please circle)
Women Business Enterprise (WBE) Yes/No
Minority Business Enterprise (MBE) Yes/No
Disadvantaged Business Enterprise (DBE) Yes/No
PLEASE CHECK ONE---CORPORATION _____ PARTNERSHIP_____INDIVIDUAL _____

For certification (WBE),(MBE),(DBE) please apply to Office of Minority & Women Business Enterprise Phone #' (302) 739-4206 (L. Jay Burks)
Fax# (302) 739-5661 Certification #_____ Certifying Agency_____

SWORN TO AND SUBSCRIBED BEFORE ME THIS _____DAY OF _____20_____

NOTARY PUBLIC_____MY COMMISION EXPIRES _____

CITY OF _____COUNTY OF _____STATE OF_____

Internet address: http://www.state.de.us/dhss/rfp/dhssrfp.htm
http://www.state.de.us/dhss/dhss.htm

Definitions

Women Owned Business Enterprise (WBE):
At least 51% is owned by a women, or in the case of a publicly owned enterprise, a business enterprise in which at least 51% of the voting stock is owned by women; or any business enterprise that is approved or certified as such for purposes of participation in contracts subject to women-owned business enterprise requirements involving federal programs and federal funds.

Minority Business Enterprise (MBE):
At least 51% is owned by minority group members; or in the case of a publicly owned enterprise, a business enterprise in which at least 51% of the voting stock is owned by minority group members; or any business enterprise that is approved or certified as such for purposes of participation in contracts subjects to minority business enterprises requirements involving federal programs and federal funds.

Disadvantaged Business Enterprise (DBE):
Any corporation, partnership, sole proprietorship, individual or other business enterprise, operating a business for profit with 100 employees or fewer, including employees employed in any subsidiary or affiliated corporation which otherwise meets the requirements of the federal small business innovation research program, except for the limitation on regarding a maximum number of company employees."

Corporation:
An artificial legal entity treated as an individual, having rights and liabilities distinct from those of the persons of its members, and vested with the capacity to transact business, within the limits of the powers granted by law to the entity.

Partnership:
An agreement under which two or more persons agree to carry on a business, sharing in the profit or losses, but each liable for losses to the extent of his or her personal assets.

Individual:
Self-explanatory

For Certification in one of above bidder must contract:
L. Jay Burks
Office of Minority & Women Business Enterprise
(302) 739-4206
Fax (302) 739-5661

Verification of certification must be submitted with bid/proposal (s) for Delaware Health and Social Services, Procurement.

POLICY MEMORANDUM NUMBER 37 March 1, 2002

SUBJECT: STANDARD ABILITY TO PAY FEE SCHEDULE

I. PURPOSE

To establish a uniform ability to pay schedule and to supplement existing collection policy or agreements to standardize Departmental collection efforts for recovery of accounts receivable that amount to less than the full cost of care due, in accordance with Delaware Code, Title 29, Section 7940.

II. DEFINITIONS

1. The "Cost of Services Rendered" in this policy shall mean the "Cost of Care" as used in Delaware Code, Title 29, Section 7940 and DHSS Policy Memorandum Number 12.

2. Disposable income for determination of ability to pay shall be gross income less a standard deduction and taxes paid.

3. Standard deduction shall be based on 100% of the poverty level.

III. EXCLUSIONS

This Policy Memorandum is not applicable to persons supported by Medicaid, Medicare, CHAMPUS, or private insurance with the exception of deductibles, coinsurance and charges for non-covered services of those payers who have contracts with DHSS facilities.

IV. FOREWORD

1. Respective Divisions shall continue to pursue recovery of the full cost of services rendered in accordance with the Department of Health and Social Services Policy Memorandum Number 12, as applicable.

2. Facilities should make every effort to assure that clients and legally liable persons are aware of and understand their fiscal liability, their right to request an adjustment to that liability, and the procedures to appeal the ability to pay determination.

3. Division Directors will develop procedures under the guidelines in Section VI for implementation of this policy within their respective Divisions.

V. PROCEDURES

A. INPATIENT SERVICES

The facility administration shall request, preferably before or, in case of emergency, after the patient is admitted or treated, a written agreement with those persons receiving or to receive care and/or treatment from the facility and, where appropriate, of the liable person(s) for the recovery of the full cost of care.(Appendix A) Liability of persons other than the patient shall be governed by the provisions of 29 Del. C. 7940 (a).The following procedures shall be implemented when a written agreement for the recovery of the full cost of services rendered cannot be obtained.

1. DHSS Ability to Pay Worksheet (Appendix B) should be completed for the person receiving care and for any other person liable under 29 Del. Code, 7940 (a), to determine disposable income and the minimum annual fee due based on the ability to pay. (Instructions on completion of the worksheet are printed on the reverse side of the form.)

2. The liability will automatically be waived for anyone with disposable income less then $6,000.

3. The liable person shall be informed, in writing, of his/her liability, due dates of payment, and appeal procedures. (Appendix C).

4. All other payment agreements, in force prior to implementation of this Ability to Pay Fee Schedule, shall be gradually phased-out, for conformance, at the time of automatic review, which is at least every two (2) years. (Delaware Code, Title 29, Section 7940, Paragraph (d).

B. COMMUNITY-BASED & OUTPATIENT SERVICES

The Divisions shall determine the ability to pay of their clients for community-based and outpatient services and shall maintain a record of this information which will be available at all service locations. The ability to pay will be determined, utilizing a sliding scale. The scale will be set using a range from 200% to 275% of the poverty level, with anyone whose gross income is at 200% or less of the poverty level, receiving the services free of charge. The percentage of charges to be paid will increase 20% for each 15% of

the poverty level, the gross income increases with anyone whose gross income is above 260% of the poverty level paying 100% of the charge. The ability to pay sliding scale will be applied to the fees which are developed and implemented by the individual divisions of DHSS for each of the services they provide. The attached Table A shows the actual income levels to be used for family levels from 1 to 10.

		200%	215%	230%	245%	260%	260%
1	$8,860	$17,720	$19,049	$20,378	$21,707	$23,036	$23,036
2	11,940	23,880	25,671	27,462	29,253	31,044	31,044
3	15,020	30,040	32,293	34,546	36,799	39,052	39,052
4	18,100	36,200	38,915	41,630	44,345	47,060	47,060
5	21,180	42,360	45,537	48,714	51,891	55,068	55,068
6	24,260	48,520	52,159	55,798	59,437	63,076	63,076
7	27,340	54,680	58,781	62,882	66,983	71,084	71,084
8	30,420	60,840	65,403	69,966	74,529	79,092	79,092
9	33,500	67,000	72,025	77,050	82,075	87,100	87,100
10	36,580	73,160	78,647	84,134	89,621	95,108	95,108
% of Charge To Be Paid		-0-	20%	40%	60%	80%	100%

Note: Federal guidelines related to specific programs take precedent over this policy.

VI. ADMINISTRATIVE DETERMINATION

Division Directors are authorized to make administrative adjustments to the monthly fee calculated by the facility in lieu of submission to the Appeals Committee, if circumstances justify such adjustments. Administrative adjustment should be made only where the individual(s) have extraordinary expenses over which they have no control (i.e., medical bills, etc.). The procedures for administrative determination shall be as follows:

1. Division Directors should establish a Review Panel, consisting if three members: the Division Director or Deputy Director, an Institutional Representative and a Community-Based Representative.

2. Upon receipt of a written request appealing the ability to pay determination, the facility administration shall notify the individual that the appeal has been received and will forward the appeal request to the Division Director's office within five (5) working days for administrative review.

3. The Review Panel will meet no less than once a month to review the appeals received and make their determination.

4. The Review Panel shall notify the facility and the individual who is making the appeal concerning their determination within five (5) working days of the review.

5. If the Review Panel concurs with the original determination, the appeal will be forwarded to the Appeals Committee for final review.

VII. APPEALS

After implementation of Ability to Pay Fee Schedule, any person aggrieved by any decision with respect to the payment of fees, refusal of admission or discharge for other than medical reasons, may appeal by petition to the Appeals Committee in writing, stating the substance of the decision appealed, the facts in support of the appeal and the relief sought.

The Appeals Committee consist of the Chairpersons of the:

o Advisory Council on Mental Retardation;
o Advisory Council on Alcoholism, Drug Abuse and Mental Health;
o Advisory Council for Delaware Hospital f/t Chronically Ill;
o Public (Physical) Health Advisory Council.

1. The Appeals Committee shall hold a hearing within sixty (60) days and shall render its decision promptly. The Committee's decision shall be final and binding.

2. The Secretary's Office will receive the appeal information, schedule the hearing and notify the Appeals Committee and the individual appealing of the date and location of the hearing.

3. The appeals hearings will be chaired on a rotating basis with each member of the committee serving as chairperson for a period of three (3) months.

Note: Appeals Committee - Delaware Code, Title 29, Section 7940, Paragraph (m).

VIII. COLLECTION

Collection efforts and write-off procedures shall be in conformance with DHSS Policy Memorandum Number 19.

IX. ADMINISTRATION

An Ability to Pay Committee shall be available to help resolve implementation/interpretation problems. It will set up such rules and regulations as are deemed necessary, pursuant to the authority granted by 29 Del. C. 7940 (j).

1. A permanent committee shall be assigned to monitor and administer the Ability to Pay Fee Schedule.

2. The Ability to Pay Committee shall consist of:
   (a) Two representatives each from the Divisions of Alcoholism, Drug Abuse and Mental Health; Mental Retardation; and Public Health;

(b) One representative from the Division of Management Services, who shall serve as Chairman.

X. EFFECT

1. This policy shall become effective on March 1, 2002.

2. Any part thereof which is inconsistent with any Federal, State or local law shall be null and void.

_____
Vincent P. Meconi
Secretary
Department of Health & Social Services

Attachment

APPENDIX A
LETTERHEAD

Patient
Name_____ Date:_____

Dear_____,

This is to advise you that the charge for services rendered at (facility) is $_____per day. The patient and/or any persons legally liable under Title 29, Section 7940 of the Delaware Code will be billed for these services.

Please complete and return this form
to_____by_____.
Financial Services Rep. (Date)

Check if Applicable:

____ 1. I have the following insurance coverage which should be billed:

------ Blue Cross
------ Medicare
------ Other Insurance
------ Medicaid

Group #_____Policy #_____
Name of Person Insured_____

____ 2. I will make full payment as billed.

____ 3. I am unable to pay the full amount.

Date_____ Signature_____

If #3 is checked, please submit the following information for our review to determine an appropriate payment based on your ability to pay.

1. A copy of your most recent Federal and State Income Tax returns.
2. A copy of all W-2 Forms submitted with your tax returns.
3. Other documents which show your current income.

You will be notified in writing of our determination. We will be unable to make any adjustments to the amount which you are required to pay if the information is not submitted.

Thank you for your cooperation.

Sincerely,

APPENDIX B

PATIENT NAME: DATE:

ADDRESS: GUARANTOR NAME:

ADMISSION DATE: ADDRESS:

INSURANCE COVERAGE:

PREPARED BY:_____

APPROVED BY:_____

1. GROSS INCOME
$_____

LESS:

2. STANDARD DEDUCTION _____

3. TAXES WITHHELD
FICA _____
FEDERAL INCOME _____
STATE INCOME _____
CITY WAGE _____

4. TAX (REFUNDS)/PAYMENTS _____

5. TOTAL DEDUCTIONS (SUM OF LINES 2-4) $_____

6. DISPOSABLE INCOME (LINE 1 LESS LINE 5)
$_____

7. MINIMUM ANNUAL FEE DUE BASED ON ABILITY TO PAY. (10% OF LINE 6)
$_____

8. MONTHLY PAYMENT. (LINE 7 DIVIDED BY 12) $_____

DHSS
ABILITY TO PAY WORKSHEET
INSTRUCTIONS

LINE 1. Gross income is obtained from a copy of the Tax Return, if one was filed, or from a copy of other payment sources (if non-taxable, such as Welfare payments, Pension payments, or other income).

LINE 2. Standard Deduction

Household Size	Amount	Household Size	Amount
1	$8,860	6	24,260
2	11,940	7	27,340
3	15,020	8	30,420
4	18,100	9	33,500
5	21,180	10	36,580

LINE 3. Taxes withheld are obtained from a copy of W-2 forms.

LINE 4. Amount of tax refunds or payments are from Federal and State tax returns.

LINE 5. Total deductions equals the sum of Lines 2 through 4.

LINE 6. Disposable income. Gross income (Line 1) less total deductions (Line 5).

LINE 7. Minimum annual fee. Is 10% of disposable income (Line 6 X .1). (The minimum annual fee will be automatically waived if disposable income is less than $6,000.)

LINE 8. Monthly payment. Annual payment (Line 8) divided by 12.

APPENDIX C

LETTERHEAD

NAME: DATE:

ADDRESS:

PATIENT NAME:

DEAR_____:

We have reviewed the information which you supplied and have calculated your minimum monthly payment according to Delaware Law 29 Del. C. 7940 and Department of Health and Social Services Policy Memorandum Number 37. You are responsible for a monthly payment of $_____for the services rendered to the above named patient. A copy of our calculation has been enclosed for your benefit. Payments are due by the 20th of the month for the previous month's care.

You have the right to appeal the determination, in writing, to the Appeals Committee stating the substance of the decision being appealed, the facts in support of the appeal, and the relief sought.

Appeals should be submitted to:

Appeals Committee Administrator

_____(Facility Name)

_____(Facility Address)

Thank you for your cooperation in this matter.

Sincerely,

DELAWARE HEALTH AND SOCIAL SERVICES

POLICY MEMORANDUM NUMBER 46 (Replaces 5/27/87)

REVISED 3/11/05

SUBJECT: STANDARDIZED REPORTING AND INVESTIGATION OF SUSPECTED ABUSE, NEGLECT, MISTREATMENT, FINANCIAL EXPLOITATION AND SIGNIFICANT INJURY OF RESIDENTS/CLIENTS RECEIVING SERVICES IN RESIDENTIAL FACILITIES OPERATED BY OR FOR DHSS

I. PURPOSE

a. To protect the right of residents/clients of Delaware Health and Social Services (DHSS) facilities to be free from abuse, neglect, mistreatment, financial exploitation or significant injury.

b. To require that each Division that has, or contracts for the operation of, residential facilities establish standardized written procedures for the reporting, investigation and follow-up of all incidents involving suspected resident/client abuse, neglect, mistreatment, financial exploitation, or significant injury.

c. To require that all DHSS residential facilities comply with The Patient Abuse Law (Title 16, Chapter 11, section 1131, et seq.) and Title 29, Chapter 79, sections 7970 and 7971 (Attachments I and II); and that all Medicaid- and/or Medicare-certified long-term care facilities and Intermediate Care Facilities for Mental Retardation (ICF/MR) comply with the federal regulations (42 CFR) and State Operations Manual for such facilities.

d. To require that all DHSS residential facilities comply with all applicable state and federal statutes, rules and regulations pertaining to suspected abuse, neglect, mistreatment, financial exploitation, or significant injury.

II. SCOPE

a. This policy applies to anyone receiving services in any residential facility

operated by or for any DHSS Division, excluding any facilities/programs in which the only DHSS contract is with the DHSS Division of Social Services Medicaid Program.

b. This policy is not intended to replace additional obligations under federal and/or state laws, rules and regulations.

III. DEFINITIONS

a. Abuse shall mean:

1. Physical abuse - the unnecessary infliction of pain or injury to a resident or client. This includes, but is not limited to, hitting, kicking, pinching, slapping, pulling hair or any sexual molestation. When any act constituting physical abuse has been proven, the infliction of pain shall be assumed.
2. Emotional abuse – This includes, but is not limited to, ridiculing or demeaning a resident or client, cursing or making derogatory remarks towards a resident or client, or threatening to inflict physical or emotional harm to a resident or client.

b. Neglect shall mean:

1. Lack of attention to the physical needs of the resident or client including, but not limited to, toileting, bathing, meals, and safety.
2. Failure to report client or resident health problems or changes in health problems or changes in health condition to an immediate supervisor or nurse.
3. Failure to carry out a prescribed treatment plan for a resident or client.
4. A knowing failure to provide adequate staffing (where required) which results in a medical emergency to any patient or resident where there has been documented history of at least 2 prior cited instances of such inadequate staffing within the past 2 years in violation of minimum maintenance of staffing levels as required by statute or regulations promulgated by the department, all so as to evidence a willful pattern of such neglect. (Reference 16 DE Code, §1161-1169)

c. Mistreatment shall mean the inappropriate use of medications, isolation, or physical or chemical restraints on or of a resident or client.

d. Financial exploitation shall mean the illegal or improper use or abuse of a client's or resident's resources or financial rights by another person, whether for profit or other advantage.

e. Significant Injury is one which is life threatening or causes severe disfigurement or significant impairment of bodily organ(s) or functions which cannot be justified on the basis of medical diagnosis or through internal investigation.

f. Residential Facility shall include any facility operated by or for DHSS which provides supervised residential services, including Long Term Care licensed

facilities, group homes, foster homes, and community living arrangements.

g. Long-Term Care Facility is any facility operated by or for DHSS which provides long-term care residential services and the Delaware Psychiatric Center.

h. High managerial agent is an officer of a facility or any other agent in a position of comparable authority with respect to the formulation of the policy of the facility or the supervision in a managerial capacity of subordinate employees.

IV. RESPONSIBILITIES

a. The Director, or his/her designee of each Division within the scope of this policy, is hereby designated as an official DHSS designee under the State Mandatory Patient Abuse Reporting Law.

b. Each Division will develop written procedures consistent with the standards contained in this policy and which will be activated immediately upon discovery of any suspected abuse, neglect, mistreatment, financial exploitation or significant injury of or to a client of a residential or long-term care facility. These procedures must clearly outline the reporting chain from the witness to the Division Director, and other appropriate parties, to require the expedient relay of information within the required time frames.

c. These standardized procedures shall also apply when the preliminary inquiry suggests that the significant injury, suspected abuse, neglect, mistreatment or financial exploitation may have been caused by a staff member of the residential facility, whether on or off the grounds of the residential facility. Suspicion of facility/program negligence (including inadequate supervision resulting in client-client altercations) and incidents involving abuse by persons who are not staff members of the residential facility shall also be reported.

d. The standardized procedures shall be approved by the appropriate Division Director prior to implementation. The Division Director or designee shall forward a copy of the approved procedures to the Chief Policy Advisor, Office of the Secretary, and other appropriate agencies.

e. Each Division will require that the standards established in this policy are incorporated in all residential operational procedures and all residential contracts. Each Division shall require that all residents and providers of these programs be informed of their specific rights and responsibilities as defined in the Division's written procedures.

f. Each Division shall require that all levels of management understand their responsibilities and obligations for taking and documenting appropriate corrective action.

g. Each Division shall require appropriate training of all staff and contract providers in the PM 46 policy and procedures. Such training shall also include the laws prohibiting intimidation of witnesses and victims (11 Del. C., sections 3532 through 3534) and tampering with a witness or physical evidence (11 Del. C., sections 1261 through 1263 and section 1269).

h. Each Division shall develop quality assurance/improvement mechanisms to monitor and oversee the implementation of the PM 46 policy and procedures.

i. Each Division must ensure that all employees of, or contractors for, residential facilities shall fully cooperate with PM 46 investigations.

V. STANDARDS/PROCEDURES

Standard and consistent implementation of this Department policy is required. Each Division's written procedures shall include the following:

a. Employee(s) of the residential facility, or anyone who provides services to residents/clients of the facility, who have reasonable cause to believe that a resident/client has been abused, mistreated, neglected, subjected to financial exploitation, or has received a significant injury shall:

1. Take actions to assure that the residents/client(s) will receive all necessary medical attention immediately.
2. Take actions to protect the residents/client(s) from further harm.
3. Report immediately to the Division of Long Term Care Residents Protection (if the incident occurred in a long-term care facility or if the client was a resident of a long-term care facility); and to the Department of Services for Children, Youth and Their Families/Division of Family Services (if the client is a minor, as required under 16 Del. C., section 903). It is essential that the reporting person ensure that the report be made to the appropriate division designee immediately.
4. Report immediately to the facility/program director and the Division's designated recipient(s) of PM 46 reports.

5. Follow up the verbal report with a written initial incident report to the persons/ agencies named in (a) 3 and (a) 4 (above) within 48 hours.

b. In addition to the above named persons, any other person may make a report to a staff person of the facility or to the Division director or his/her designee. Such a report shall trigger activities under V(a), items 1 through 5.

c. Each written initial report of suspected abuse, neglect, mistreatment, financial exploitation, or significant injury (completed by the reporting employee) must include:

1. The name and gender of the resident or client.
2. The age of the resident or client, if known.
3. Name and address of the reporter and where the reporter can be contacted.

4. Any information relative to the nature and extent of the abuse, neglect, mistreatment, financial exploitation or significant injury.
5. The circumstances under which the reporter became aware of the abuse, neglect, mistreatment, financial exploitation or significant injury.
6. The action taken, if any, to treat or otherwise assist the resident or client.
7. Any other information that the reporter believes to be relevant in establishing the cause of such abuse, neglect, mistreatment, financial exploitation or significant injury.
8. A statement relative to the reporter's opinion of the perceived cause of the abuse, neglect, mistreatment, financial exploitation or significant injury (whether a staff member or facility program negligence).

d. The Division's designated recipient of PM 46 reports shall report all allegations of abuse, neglect, mistreatment, financial exploitation and significant injury, to the Office of the Secretary; the Office of the Attorney General/Medicaid Fraud Control Unit (for Medicaid- and/or Medicare-certified long-term care facilities); the appropriate state licensing agency for the program, if applicable; and the Division Director or designee, within 24 hours of receiving notification of such.

e. In instances where there is immediate danger to the health or safety of a resident/client from further abuse, mistreatment or neglect; if criminal action is suspected; or if a resident/client has died because of suspected abuse, mistreatment, neglect or significant injury, the Division Director or his/her designee shall immediately notify the appropriate police agency. The Division of Long Term Care Residents Protection, and the Office of the Secretary, shall be notified if the police were contacted. Further, the Division Director or his/her designee shall notify the Office of the Attorney General/Medicaid Fraud Control Unit, the Office of the Secretary, and the Chief Medical Examiner, if a resident/client has died because of suspected abuse, mistreatment, neglect, significant injury, or as a result of any cause identified by 29 Del. C., section 4706.

f. The Division Director or his/her designee shall review the initial incident report and initiate an investigation into the allegations contained in the report. The investigation, with a written report, shall be made within 24 hours, if the Division has reasonable cause to believe that the resident's/client's health or safety is in immediate danger from further abuse, neglect or mistreatment. Otherwise, the investigation and written Investigative Report, up to and including the Division Director's or designee's signed review of the report, shall be made to the Division of Long Term Care Residents Protection (DLTCRP) within 10 days. This timeframe may be extended by DLTCRP if extenuating facts warrant a longer time to complete the investigation. If the facility is a Medicaid-Medicare certified long-term care facility, or an ICF/MR facility, the report of suspected abuse, neglect, mistreatment, financial exploitation or significant injury shall be sent to the appropriate authorities, as required in the respective regulations under 42 CFR, within 5 working days of the incident.

g. The investigative process shall be confidential and not subject to disclosure both pursuant to 24 Del. C., section 1768 and because it is privileged under the governmental privilege for investigative files. Each Investigative Report shall be

labeled as confidential and privileged, pursuant to 24 Del. C., section 1768. Each investigation shall include the following:

1. A visit to the facility or other site of incident.
2. A private interview with the resident or client allegedly abused, neglected, mistreated, whose finances were exploited or whose injury was significant.
3. Interviews with witnesses and other appropriate individuals.
4. A determination of the nature, extent and cause of injuries, or in the case of exploited finances, the nature and value of the property.
5. The identity of the person or persons responsible.
6. All other pertinent facts.
7. An evaluation of the potential risk of any physical or emotional injury to any other resident or client of that facility, if appropriate.

h. A written report (Investigative Report) containing the information identified in V (g) shall be completed within the time frames identified in V (f) and shall include a summary of the facts resulting from the investigation. (Attachment 3)

i. The Investigative Report shall be sent to the facility director and to the Division Director or designee. The Facility Director and the Division Director or designee shall review the report. If the incident is serious, the Division Director must review the incident with the Department Secretary prior to the completion of the report. The Facility Director and the Division Director or designee shall indicate in writing their concurrence or non-concurrence with the report. If the facts show that there is a reasonable cause to believe that a resident/client has died as a result of the abuse, neglect, mistreatment, or significant injury, the Division Director or designee shall immediately report the matter to the Office of the Attorney General/Medicaid Fraud Control Unit, the Division of Long Term Care Residents Protection, and the Office of the Secretary.

j. All Investigative Reports shall be forwarded by the reporting division, forthwith, to the Division of Long Term Care Residents Protection. The Division of Long Term Care Residents Protection shall complete the investigation by making a determination of findings and documenting their conclusions.

k. If a determination is made at the Division level (upon consultation with the Division of Management Services, Human Resources office) that discipline is appropriate, the Investigative Report shall be forwarded to the Human Resources office. Human Resources shall determine the appropriate level of discipline, forward their recommendations to the Office of the Secretary and to the originating division for implementation, and proceed as appropriate.

l. The Office of the Secretary shall be informed by the Division of Long Term Care Residents Protection, in writing, of the results of the investigation, including the findings and recommendations, within 5 days following the completion of the investigation.

m. The Division Director or designee shall notify the appropriate licensing or registration board, if the incident involved a licensed or registered professional, and the appropriate state or federal agency, including the appropriate state

licensing agency of the program, if applicable, upon a finding of: 1) abuse, mistreatment, neglect, financial exploitation, or significant injury; 2) failure to report such instances by a licensed or registered professional; or 3) failure by a member of a board of directors or high managerial agent to promptly take corrective action.

n. The Division Director or designee shall notify the employee, resident/client, the guardian of the resident/client, if applicable, and the incident reporter of the results of the facility-based case resolution, unless otherwise prohibited by law. They shall also advise the parties of the fact that there is a further level of review that will occur through the Division of Long Term Care Residents Protection and/or the Office of the Attorney General/Medicaid Fraud Control Unit.

o. The Division of Long Term Care Residents Protection shall, at the conclusion of their review of the case, notify the DHSS employee (or the agency director for contract providers), the resident/client, or the guardian of the resident/client, if applicable, and the originating Division Director or designee, of the substantiated or unsubstantiated status of the case, unless otherwise prohibited by law. The

Division of Long Term Care Residents Protection shall also notify the Office of the Attorney General/Medicaid Fraud Control Unit of all substantiated cases.

VI. IMPLEMENTATION

a. This policy shall be effective immediately (upon the completion of mandatory
departmental training).

b. In carrying out this policy, all parties must protect the confidentiality of records and persons involved in the case, and may not disclose any Investigative Report except in accordance with this policy.

VII EXHIBITS

a. Attachment 1 – Delaware Code, Title 16, Chapter 11, Sections 1131-1140.

b. Attachment 2 – Delaware Code, Title 29, Chapter 79, Sections 7970-7971.

c. Attachment 3 – Investigative Report form

Vincent P. Meconi

Vincent P. Meconi
Secretary

ATTACHMENT 3

RFP PSC - 0733

DELAWARE DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

PROGRAM PROPOSAL BUDGET GUIDELINES---PSC - 0733

OVERVIEW

The budget categories and line items described below have been adapted from and are consistent with similar procedures used by DSAMH in the development of budgets and rates for many of its current alcoholism, drug abuse and mental health programs. To aid DSAMH in comparing programs and budgets across all proposer agencies and programs, all proposers are requested to submit budget proposals in a common budget format.

The Division recognizes that providers will incur both direct and indirect (i.e., overhead) costs, in providing services to clients. These procedures are intended to guide potential providers in developing a program budget which represents fairly the reasonable and necessary costs they incur in serving clients.

ALLOWABLE COSTS

Program costs may be classified into two components. These are:

- Direct Costs
- Indirect Costs

Direct Costs are those costs which can be readily identified with the specific program or service provided. As an example, the salary of a clinician who is assigned full time to the proposed Program is readily identifiable and easily associated with the Program. Indirect Costs are those costs which cannot be specifically identified with a service. As an example, the payroll function of an organization which operates multiple programs, cannot be easily associated with the specific service provided.

Those cost elements which cannot be readily associated with a service must be accumulated in a cost pool (i.e., the Indirect Cost Pool) and then allocated on a rational basis to the
various provider programs which share or benefit from the incurrence of the costs.

It should be noted that an Indirect Cost element for some providers could be considered to be a Direct Cost for other providers. Building upon the example of the payroll function, a provider which operates only one program could consider the

payroll function to be a Direct Cost since all payroll costs would be readily identifiable with the single program operated by that provider.

Since these procedures must accommodate providers with somewhat different operating structures, it has been necessary to establish decisional rules as to which cost elements will be classified as Direct or Indirect Costs. These decisional rules establish comparability of cost treatments across all providers.

DIRECT COSTS

The following cost elements are considered to be Direct Cost elements which, subject to the conditions and restrictions set forth in conjunction with the definition, constitute allowable Direct Costs for purposes of developing the provider budget. The cost elements are generally arrayed in the order in which they appear on the DSAMH Program Budget Form.

Direct Personnel Costs

In calculating allowable Direct Personnel Costs, providers must prorate the salaries of employees across all programs in which those employees serve. As an example, if an employee works half-time in the proposed Program and half time in another provider program, only 50 percent of the employee's salary would be assigned to the proposed Program.

Providers are required to institute and maintain reporting systems which identify an after-the-fact determination of the actual activity of each employee who performs activities for both the proposed Program and other programs operated by the provider. The activity reporting requirement is not necessary for staff who work exclusively (i.e., on a full time basis) on (proposed) Program activities.

The reporting system for employees with multi-program work responsibilities:

- must account for the total activity for which employees are compensated
- must be signed by the individual employee to attest that the distribution of activity reported reasonably reflects the actual work performed by the employee during the report period.

Direct Personnel Costs for the proposed Program may include:

- salaries and wages
- supplemental compensation, including bonuses (**providers must attach all relevant policies and procedures to the budget submission if this cost component is included in Direct Personnel Costs**)
- sick pay
- holiday pay

- vacation pay

- shift differential pay.

Fringe Benefit Costs - Fringe benefit costs for Program Personnel are allowable if they are provided as a part of the conditions of employment. Allowable Fringe Benefit Costs include three categories of fringe benefit costs. These categories are:

- payroll tax (i.e., the employer's portion of FICA)

- health benefit costs

- other fringe benefit costs. Other fringe benefit costs may include such costs as:

  Pension/Retirement
  State Unemployment Insurance
  State Industrial Insurance
  Uniforms (Job Related).

Providers who are operating multiple programs may employ the following methodology to determine the allocation of each category of fringe benefit costs to the proposed Program. The
payroll tax category of fringe benefit costs has been used for illustrative purposes.

1. Calculate total salary costs for all provider personnel for all programs including administrative functions.

2. Calculate total payroll tax costs for all provider staff.

3. Divide total payroll tax costs (step 2 above) by total salary costs (step 1 above). This calculation is the percentage of salary costs attributable to payroll tax (i.e., the payroll tax rate).

4. Multiply salary costs of Program personnel by the payroll tax rate determined from step 3 above. This calculation is the allowable payroll tax cost assignable to the proposed Program.

Health Benefit Costs and Other Fringe Benefit Costs may be allocated using this same methodology.

Other rational bases for allocating fringe benefit costs are also allowable provided that:

- the methodology is documented in the provider's files

- the methodology is not changed from year-to-year without the prior consent of DSAMH.

Consultant Costs - Consultant costs which are allowable costs include:

- accounting and auditing services
- management consulting
- engineering and architectural services
- special legal services
- other contracted professional and technical services.

If a consultant service benefits other provider programs in addition to the proposed Program, the consultant cost must be prorated between the proposed Program and the other provider programs sharing the benefits of the consulting service. Again the allocation basis must be a rational system which is both documented and consistently applied from year-to-year. As an example, a rational system for allocating contracted architectural services would be the square footage of the provider facility assigned to each respective program which benefited from the architectural change. If square footage is adopted as the allocation methodology for contracted architectural services, then this methodology must be maintained in ensuing contract years. Prior approval of DSAMH is required before an allocation methodology can be changed by the provider.

A copy of the contract document should be maintained on file at the program site.

Contractual Staff Costs - Providers may contract with staff in lieu of hiring these staff as employees. The costs of contracted staff are allowable costs subject to the following conditions.

1. Contracted Direct Care staff must meet the skills and experience criteria required for the performance of direct care services expected to be rendered.

2. Contracted staff must be included in the calculation of full time equivalent (FTE) employees assigned to the program.

3. If a contracted individual is assigned to several provider programs, the provider must record time spent by the individual working in each program, and allocate contract costs between the programs on the basis of time spent in each program.

4. A copy of the contract with the staff individual should be maintained on file at the program site.

Staff Training Costs - Staff training costs are allowable costs under the following circumstances. The training costs must be incurred by the provider for planned, structured training activities for the purpose of improving, enhancing or extending

job related knowledge and skills of provider staff or contracted provider staff. Trainee salary costs should not be considered a staff training cost.

Travel costs associated with transporting staff to a training site or lodging staff during a training event should not be reported as a training cost, but rather should be recorded as a Transportation and/or Meals and Lodging Cost.

Staff Mileage Costs - Staff mileage costs are allowable costs if the mileage is incurred while traveling on Program business. Mileage to and from the staff person's residence to the program work site is not an allowable cost.

Provider reimbursement rates for employee mileage may not exceed the guidelines established for each Tax Year by the Federal government for business use of vehicle.

To document employee mileage reimbursement requests, the provider must establish policies that collect at a minimum the following data elements from staff requesting mileage reimbursement:

- the date on which the travel took place
- the name of the client visited or the purpose of the travel for non-client related travel
- the location at which the travel started and the destination location
- the mileage for the trip
- the name of the staff person incurring the mileage expense.

Staff Public Transportation - Public Transportation costs include commercial airlines, rail transportation and cab service. These costs are allowable if the travel is for the purpose of Program business. **Travel costs in excess of "coach class" fares are not allowable.**

Providers should document transportation costs in a manner similar to that described above for "Staff Mileage Costs". In addition, receipts for commercial carriers should be maintained in the provider's files.

Meals and Lodging Costs - Reasonable meal and lodging costs which are associated with travel are allowable costs subject to the following limitation:

1. Meals and Lodging Costs are only allowable for staff members or contracted Care workers assigned to the proposed Program.
2. Meal costs are allowable only if the staff person is in an overnight travel status.
3. Entertainment expenses incurred by a program staff member on behalf of or for the benefit of a third party are not allowable.

4. Meal and lodging costs are allowable only if the costs are incurred in relationship to proposed Program business.

The provider should establish internal procedures which document expenditures for meals and lodging. These reporting procedures should parallel those described in association with "Staff Mileage Costs". Receipts should be maintained for all staff lodging costs.

Occupancy Costs (Rental Facilities) - Subject to the limitations described below, rental costs for building facilities are allowable to the extent that the rates are reasonable in light of such factors as: rental costs of comparable property; market conditions in the area; alternatives available; and the type, condition and value of the property leased.

1. Rental costs under sale and leaseback arrangements are allowable only up to the amount that would be allowed had the provider agency continued to own the property.

2. Rental costs under less-than-arm's-length leases are allowable only up to the amount that would be allowed had title to the property vested in the provider agency. A less-than-arm's-length lease is one under which one party to the lease agreement is able to control or substantially influence the other.

3. Rental costs under leases which create a material equity in the leased property are allowable only up to the amount that would be allowed had the provider agency purchased the property on the date the lease agreement was executed including depreciation and allowable interest expenses.

4. Rental costs for facilities which house multiple provider programs must be allocated on a rational basis to the programs sharing the facility.

Occupancy costs for building rental are a separate cost element and should be accumulated and reported separately and distinctly from other occupancy related cost categories described below.

Note: Costs associated with any rental of client housing should not be included in the Occupancy Cost category. Client housing costs are allowable and reimbursable ONLY in specifically designated DSAMH program types. Budget form instructions appearing below require a complete explanation of this expense category if budgeted.

Occupancy Costs (Provider Owned Facility) - Providers may be compensated for the use of their owned facilities through:

- a depreciation or use allowance

- the allowability of interest charges for capital indebtedness.

Depreciation is an allowable cost provided that:

1. The computation of the depreciation allowance excludes the cost of land.

2. The computation of the depreciation allowance is based upon the acquisition cost of the facility.

3. The method of depreciation used to assign the cost of an asset to accounting periods shall reflect the pattern of consumption of the asset during its useful life. A straight line method of depreciation should be used if there is no clear evidence that the expected consumption of the asset will be greater/lesser in the earlier/later portions of its useful life.

4. A depreciation method that has been adopted for a provider owned facility may not be changed at some future point in time without the prior approval of DSAMH.

Interest charges on capital indebtedness are also an allowable cost. Mortgage interest refers to the interest expense incurred by the borrower on a loan which is secured by a mortgage.

Mortgage loans are customarily liquidated by periodic payments over the term of the mortgage. These periodic payments include both interest and principal. The interest portion of the mortgage payment is an allowable cost. **Principal payments are <u>not</u> an allowable cost.**

Interest charges on capital indebtedness are allowable under the condition that the rate is not in excess of what a prudent borrower would have had to pay in an arm's length transaction in the money market when the loan was made.

Note: All remaining categories of occupancy related costs (e.g., rent, utilities, taxes, etc.) for providers operating multiple facilities or multiple programs within a single facility must be allocated on a rational basis to the programs sharing or using the facility. These other categories of occupancy costs are described below.

<u>Real Estate Taxes and Property Insurance</u> - Taxes and property insurance on the provider facility are an allowable cost.

<u>License, Permits, Fee Costs</u> - The cost of state or local licenses or permits necessary for the provider to operate the building facility and/or offer proposed Program services are allowable costs.

<u>Utilities</u> - Utility costs associated with the operation of the proposed Program are allowable costs.

<u>Repair and Maintenance Costs</u> - This expense category is used to record the costs of labor and/or supplies furnished by other than provider staff for the repair and maintenance of the facility or facility capital equipment used by the proposed Program. Repair and maintenance costs are an allowable cost.

<u>Rent</u> - See "Occupancy Costs" (Rental Facilities) above.

Custodial Supplies - Custodial supply costs include the costs of supplies which are purchased and consumed within the facility such as for cleaning and sanitation purposes. Custodial supply costs are an allowable cost.

Insurance Costs - Insurance costs include the cost of coverage for fire, theft, liability, and other forms of insurance which are not directly related to:

- Employee benefits. Insurance related to employee benefits such as health insurance or life insurance should be recorded as a "Fringe Benefit" cost.

- Motor vehicle insurance. Automobile insurance for provider owned or leased vehicles should be recorded as a "Vehicle Insurance and Tax" cost.

- Professional Liability. Insurance related to coverage of the agency or staff for malpractice or similar liability should be recorded as an "Other Operational" cost.

Reasonable costs to insure the building facility and staff from loss or liability are allowable costs. Insurance costs must be prorated on a rational basis to the programs which share the facility being insured.

Other - This cost category includes other building occupancy costs not otherwise classified as a distinct cost category. Examples include laundry services, cleaning services, contracted custodial services and lawn and grounds maintenance. These costs are allowable, if they are reasonable and necessary for the operation of the proposed Program.

Vehicle Operations Costs (Vehicles Owned by the Provider) - Providers may be compensated for the use of provider owned vehicles assigned to or used by Program staff in the official conduct of their program duties. Two alternative options may be utilized.

Option #1 - Under this option providers may charge the program the applicable guideline amount for miles driven on Program business. This mileage rate is all inclusive of gasoline, insurance, depreciation and maintenance. Providers electing this option need only prorate mileage between the proposed Program and:

- other programs if the provider operates multiple programs which share the use of the vehicle

- personal use, if the vehicle is used on occasion for other than official Program business.

The allocation described above can be readily accomplished by maintaining a trip log in each vehicle. Individuals using the vehicle should note:

- the program to which the mileage is assignable

- the client visited or other program related reason for Program business

- the individual using the vehicle
- the starting location and destination for the trip
- the mileage for the trip.

The trip log serves as documentation of program miles driven and permits the rapid calculation of costs attributable to the Program.

Option #2 - Under this option providers may elect to be compensated for provider owned vehicles through the form of:

- a depreciation allowance for the vehicle
- reimbursement for interest for capital indebtedness for the vehicle
- reimbursement for vehicle operating and maintenance costs (e.g., gas, oil, and insurance).

Providers electing this option are required to select a depreciation allowance method which:

- is based upon the acquisition cost of the vehicle
- assigns the cost of the asset to accounting periods in a way which reflect the consumption of the asset during its useful life.

If the vehicle is not dedicated exclusively to the proposed Program, the depreciation allowance must be allocated on a rational basis between the proposed Program and other programs sharing the use of the vehicle.

Interest charges for indebtedness for the vehicle are also allowable providing that the interest rate is not in excess of what a prudent borrower would have had to pay in an arm's length transaction in the money market when the loan was made.

The portion of the monthly payment to the fiscal agent which is attributable to principle reduction is not an allowable cost. Interest charges on the asset must also be allocated to the program sharing the use of the vehicle if the vehicle is not exclusively dedicated to the proposed Program. The same allocation methodology used to calculate the pro rata share of depreciation costs assignable to the proposed Program should be used to allocate interest.

Vehicle Operations Costs (Leased Vehicles) - The cost of leasing a vehicle is an allowable Program cost provided that the lease rate is not in excess of what a prudent borrower would have had to pay in an arm's length transaction at the time that the lease was entered into.

Certain leases contain options which allow the leaser to acquire the vehicle at a rate below fair market value at the conclusion of the lease period. Providers selecting lease arrangements of this nature must make a pro rata adjustment in the lease rate charged to the proposed Program to reflect the share of the asset's value which will be acquired at the conclusion of the lease period by virtue of the option to buy discount.

If the vehicle is shared by other provider programs, the cost of the lease must be allocated to participating programs on a rational basis.

Gas and Oil Costs - Gas and oil costs to operate vehicles are allowable for:

- providers operating leased vehicles
- providers electing the Option #2 form of costing for provider owned vehicles. See "Vehicle Operations Costs (Vehicle Owned by Provider)".

Providers with multiple programs which share a vehicle must allocate Gas and Oil costs among user programs on a rational basis.

Vehicle Repair and Maintenance Costs - Vehicle repair and maintenance costs are allowable costs to the extent that these costs are not recoverable:

- from an insuring entity
- from the leasing entity, if applicable
- as a car warranty reimbursement.

Providers must have elected the Option #2 form of costing for provider owned vehicles in order to receive reimbursement for Vehicle Repair and Maintenance Costs. See "Vehicle Operations Costs" (Vehicle Owned by Provider).

Providers with multiple programs which share a vehicle must allocate vehicle repair and maintenance costs among user programs on a rational basis.

Vehicle Lease Costs - See "Vehicle Operations Cost (Leased Vehicles)" above.

Vehicle Insurance and Tax Costs - Vehicle insurance and tax costs are an allowable cost if the provider elected the Option #2 form of costing provider owned vehicles. See "Vehicle Operations Costs" (Vehicle Owned by Provider). Tax costs which are allowable include:

- title and transfer fees
- state and local use permits (i.e., license plates and municipal stickers)
- other vehicle taxes which are necessary and reasonable to the operation of the vehicle.

Providers with multiple programs which share a vehicle must allocate vehicle insurance and tax costs among user programs on a rational basis.

Contractual Transportation - Providers may occasionally find it necessary to rent special purpose vehicles such as a bus or a van to transport large numbers of program staff to a location. Costs of contractual transportation of this nature are allowable if the purpose of the activity associated with the contractual transportation is for the purpose of a legitimate Program function.

Public Transportation (Client) - Public transportation costs for clients even if the purpose of the transportation is directly related to the provision of authorized services and the client is economically unable to personally fund the public transportation costs are allowable and cost-reimbursable ONLY in specifically designated DSAMH program types.

Provider staff public transportation costs may not be charged or recorded to this cost category.

Other - Additional costs associated with the operation and use of vehicles which are not appropriate to a previously described cost category should be recorded as a part of this cost category.

Examples might include:

- garage fees or parking fees
- alteration of vehicle to accommodate the handicapped clients.

These miscellaneous costs are allowable if the vehicle incurring these miscellaneous costs is used for proposed Program functions.

Food and Grocery Costs - Food and grocery costs for Program clients are allowable and cost-reimbursable ONLY in specifically designated DSAMH program types.

Educational Supplies - Educational supplies for Program clients are allowable and cost-reimbursable ONLY in specifically designated DSAMH program types. If allowable, these costs should be calculated at their actual prices after deducting all cash discounts, trade discounts, rebates and allowances received by the provider agency.

Miscellaneous Client Expenses - The provision of emergency funds or other direct payments to clients is allowable and cost-reimbursable ONLY in specifically designated DSAMH program types. If allowable, this category would include the cost of providing prescription and non-prescription drugs purchased and administered to the client and other assistance provided directly to clients which does not fall into any other specified category of client costs. **This cost is to be submitted in the Client Assistance Budget rather than the operating budget.**

Client Rental Assistance - The cost associated with providing housing or rental assistance to clients is allowable and cost-reimbursable ONLY in specifically designated DSAMH program types. **This cost is to be submitted in the Client Assistance Budget rather than the operating budget.**

Other Client Expenses - See "Miscellaneous Client Expenses" above.
This cost is to be submitted in the Client Assistance Budget rather than the operating budget.

Operating Expenses - Certain categories of operating costs are allowable if they are directly assignable and traceable to the proposed Program. Allowable operating expenses for the proposed Program include reasonable and necessary costs for:

- telephone
- postage
- printing and reproduction
- office supplies
- equipment rental
- equipment repair and maintenance
- other miscellaneous operating expenses.

These costs are generally allowable only if they are separate and distinct from the operating expense cost elements of other programs operated by the provider. If these cost elements are shared by other provider programs, these costs should be allocated as an indirect cost rather than as a direct program cost.

In order to claim operating expenses as a direct rather than indirect cost, the provider must establish and enforce procedures which prevent the commingling of operating cost elements between programs. As examples:

- office supplies for the proposed Program should be stored at the program location and kept physically apart from office supplies for other provider programs
- the phones used at the program location should be separately billed by the phone company
- equipment rented should be physically situated at the proposed program location and must not be shared with other programs.

Operating expenses can be most readily isolated if the proposed Program is assigned a finite space within the provider's facility. Equipment, phones and office supplies can then be isolated at the proposed program location.

Advertising Costs - Advertising costs except for recruitment of proposed Program personnel are not allowable costs

All allowable Direct Costs for the proposed Program constitute the "Direct Cost pool" for the proposed Program.

UNALLOWABLE ITEMS OF COST

Direct Costs were discussed above in relationship to the Program budget form currently utilized by DSAMH in establishing budgets for providers of contractual services.

To further guide providers in understanding which cost elements are not allowable Program costs, a listing of unallowable cost elements is presented below. This listing is not intended to be all inclusive, but rather is intended to note major cost elements with which providers have experienced problems.

Unallowable Program cost elements which cannot be incorporated into the budget provider costs for:

- Bad Debt
- Contingency Provisions or Contingency Reserves
- Contributions
- Donations
- Entertainment Costs
- Equipment Costs or Other Capital Expenditures (Note: although the acquisition cost of equipment, land and facilities is not allowable, providers are allowed to claim depreciation and interest on mortgages and other capital plan loans).

EXCEPTION: [Initial acquisition costs for equipment and other capital items may be reimbursable by DSAMH under a contractual cost-reimbursement provision of MOST DSAMH cost-reimbursement contracts--See budget form instructions.] [This cost IS considered allowable for the program requested under PSC - 0733].

- Fines and Penalties
- Idle Facilities and Idle Capacity
- Fund-Raising Costs
- Investment Management Costs
- Interest other than for Capital Expenditures

- Losses on Other Contracts or Previous Contracts

- Organization Costs such as incorporation fees or fees to
- promoters and organizers

- Participant Support Costs

- Pre-Award Costs which include all costs incurred prior to the effective date of DSAMH's service agreement with the provider

- Public Information Services Costs

- Publication Costs.

DSAMH has modeled its definition of allowable/unallowable costs on Federal guidelines. A more detailed listing of allowable and unallowable cost elements is presented in the Code of Federal Regulations (CFR). Providers seeking guidance with respect to a cost element not referenced as either allowable or unallowable should consult the CFR for further guidance.

INDIRECT COSTS

An indirect cost is one which, because of its incurrence for common or joint objectives, is not readily subject to treatment as a direct cost.

After direct costs have been determined and charged directly to the programs operated by the provider, indirect costs are those residual costs which remain to be allocated.

The residual costs remaining to be allocated will normally be summed into a pool of costs termed the Indirect Cost Pool and then allocated back to the alternative cost centers (i.e., programs) operated by the provider.

The steps associated with creating and allocating indirect costs are described below.

IDENTIFICATION OF INDIRECT COST ELEMENTS

Only providers who operate additional programs beyond the proposed Program are required to prepare an Indirect Cost allocation plan. This is the case because providers who are operating only the single proposed Program should be able to classify all costs as direct costs.

Providers with multiple programs should calculate their Indirect Costs so that these costs can be incorporated into the development of their program budgets.

The initial step in developing Indirect Costs is to define direct costs for each program operated by the provider. A separate direct cost pool must be created for each specific program.

Earlier, the procedures to develop direct costs for the proposed Program were defined. A similar procedure should be used in creating direct costs for other programs operated by the provider.

It should be noted that other programs may have additional direct cost elements which are not utilized in the proposed Program. These additional elements of direct costs should be included as
appropriate in the construction of direct cost pools for other provider operated programs.

After all direct costs have been assigned to their respective programs and cost pools, the residual of unassigned provider costs constitutes the preliminary Indirect Cost pool to be allocated. Two additional steps must be performed before this preliminary pool of Indirect Costs can be allocated to the proposed Program and other programs operated by the provider.
These steps are:

- purifying the preliminary indirect cost pool by excluding unallowable indirect costs

- creating an allocation methodology which rationally allocates indirect costs to the respective programs operated by the provider.

These steps are described in more detail below.

EXCLUDING UNALLOWABLE INDIRECT COST ELEMENTS

After residual unassigned costs have been identified and aggregated into the preliminary Indirect Cost pool, each Indirect Cost element should be reviewed to determine whether it is an allowable or unallowable cost element. The same rules which applied to allowability or unallowability of Direct Cost elements also applies to Indirect Cost elements. The discussion of direct costs, above, defines the most commonly encountered "unallowable" cost elements.

Providers should compare their Indirect Cost elements with the listing above and exclude those cost elements which are "unallowable". The Code of Federal Regulations (CFR) should also be consulted if there is a question regarding the allowability of any specific Indirect Cost element.

After "unallowable" cost elements have been deducted from the preliminary Indirect Cost pool, the residual cost elements constitute the provider's Indirect Cost pool. The specific cost elements which comprise this Indirect Cost pool should be documented and maintained on file for periodic review by DSAMH personnel.

ALLOCATING THE INDIRECT COST POOL TO THE PROGRAMS OPERATED BY THE PROVIDER

In order to allocate the Indirect Cost pool to the various programs operated by the provider, it is necessary to construct an allocation methodology which will rationally allocate Indirect Costs to the programs in a proportionate manner which reasonably reflects the benefit each program receives from the Indirect Cost expenditures.

Acceptable methodologies for allocating Indirect Costs to the programs include prorations based upon:

- total Direct Costs, or
- total direct salaries and wages.

These simplified methods of allocating Indirect Costs are permissible if there are no known environmental factors which would substantially affect the Indirect Costs applicable to a particular segment of the provider's programs.

Providers who believe that one of the simplified allocation methodologies described here would be inappropriate for their organizations should consult with DSAMH regarding alternative permissible allocation methodologies for Indirect Costs.

Once a provider has established the allocation methodology to be used for distributing Indirect Costs, this same methodology must be used in making future year's allocations. The provider must make a written request to DSAMH for approval of a change in methodology and must submit reasonable justification for the requested change. A change in allocation methodologies must be approved in writing by DSAMH before it may be used by the provider.

LIMITATION ON INDIRECT COSTS

For purposes of cost containment DSAMH has established a ceiling for Indirect Costs. This ceiling is 12.0 percent of total Program allowable Direct Costs.

Providers may claim the lesser of their pro rata allocation of indirect costs to the proposed Program or 12.0 percent of total allowable proposed Program Direct Costs.

PROCEDURES FOR DEVELOPING THE BUDGET PROPOSAL

Proposers are requested to submit budgets which have been prepared in accordance with the foregoing guidelines regarding allowable/unallowable costs on the forms provided.

BUDGET PREPARATION INTRODUCTION

Form D of PSC - 0733 contains an example of the budget format to be used for budget proposals.

BUDGET PREPARATION INSTRUCTIONS

The first sheet of the budget form contains summary information about the proposed program and budget. Each item number below refers to a corresponding number on Budget Proposal (Form D):

Item 1 - Provider Name. Enter the name of your organization as it should appear on official contract documents.

Item 2 - Name of Contact Person. Identify the name of an individual within your organization who is knowledgeable about the budget you have submitted and who is authorized by your organization to discuss it.

Item 3 - Contact Person's Phone Number. Provide a phone number for the contact person identified in Item 3 above.

Item 4 - Program Name. Enter the program name for the program which this budget has been prepared for. Generally, the Program should constitute an identifiable cost center or budget entity within the Proposer's organization. [For proposals in response to PSC -0733, the program name may be entered as "AOD Day Treatment Program".]

Item 5 - Budget Period. Enter in this item the time period over which the budget is intended to support the proposed program (e.g.: July 1, 2001 through June 30, 2002).

The remainder of the budget submission format requests information regarding program costs by cost category. When entering cost data, providers should refer to previously provided instructions to ensure that cost elements reported on the budget form are allowable and fully conform with the procedures identified.

Item 6 - Direct Personnel Staff Roster. Enter the name and Functional Title of each individual who will participate in the proposed Program in the year being budgeted. The following additional instructions should be considered when making Item 6, Staff Roster, entries.

a) The staff roster should include both salaried employees and contracted employees who will participate in the program. Consult Item 48 for more information on the differences between contracted staff and consultant costs.

b) If a position is not currently filled, but you intend to fill the position sometime during the budget year, insert the word "vacant" in place of a staff name.

c) Consideration should be given as to whether employees/contract staff are directly a part of the proposed Program or should more appropriately be considered as an indirect cost of the program. (See previous discussion of Direct and Indirect Costs).

Item 7 - Employee Status. For each position listed in the staff roster in Item 8, indicate whether the staff person is a salaried employee or a contracted employee. Enter an "S" for salaried employees or enter a "C" for contracted employees.

Item 8 - Full Time Equivalent. Item 8 is intended to capture the percentage of time that each individual will be dedicated to the proposed Program.

Enter the value "1.0" (one) for each person who will be dedicated on a full time basis to the Program you are budgeting for.

Some staff may be assigned to the program on less than a full-time basis. In these situations enter the percentage of time this individual will be dedicated to this program.

As examples of this point:

- a half-time employee would be coded .50

- an employee that is assigned one third time to each of three separate programs operated by the provider would be coded as a .33 full-time equivalent to each of the three programs.

Additionally, some full-time staff may be hired later in the contract year (e.g., employment month of January), especially in the start up year of a proposed Program. In these cases, the full-time equivalent percentage should be adjusted to reflect a planned full-time hire who will work less than the full 12 months of the contract year in which he was employed. For example, a full-time staff with a planned employment date in month six of the contract year would be coded as a .5 FTE in his first year and 1.0 FTE in subsequent contract years. **[The budget proposal narrative must indicate positions for which the FTE and budgeted amounts are affected by this delayed-hire provision.]**

Item 9 - Total Full Time Equivalent (FTE) Staff. Add the FTE amount for each entry in Item 8 and enter the total of these FTEs as Item 9.

Item 10 - Program Direct Staff Costs. For each functional position listed in the Staff Roster, Item 6, indicate the wages or contract amounts to be

paid to that individual for the budget year which are assignable to the proposed Program as a program cost.

Individual program costs may or may not be a percentage of an employee's wages. Employees who are assigned to more than one provider program must have their wages allocated to each of the programs they are assigned to.

Additionally, some providers may choose to use other funding sources to offset a portion of a particular employee's wage costs. Such sums would be deducted from the wages assigned as a contract cost.

For salaried employees, annual compensation includes salary, shift differentials and bonuses. If employees are likely to receive salary increases during the budget year, the amount of these salary increases should be included on a pro rata basis adjusted for the effective date of the salary increase.

For contracted staff, annual compensation will likely include both compensation and fringe benefits since most personal services contracts do not separately identify that portion of the contractor's fees which are assignable to fringe benefits.

Note: Providers must execute a personal services contract with each contracted employee. This contract must be maintained on file for periodic inspection by DSAMH officials. At a minimum the personal services contract must identify:

- the services to be provided by the contract employee
- the Program functional title that will apply to the contract employee
- the rate per hour the contract employee is to receive
- the maximum hours that the contract employee is allowed to bill during the budget year
- the contract maximum. This is the rate per hour multiplied by the maximum hours which the contract employee may bill.

Item 11 - Total Program Direct Staff Costs. Add the cost for each entry in the Program Direct Staff Cost column (Item 10) and enter the total in Item 11.

Item 12 - Payroll Tax. Enter the payroll tax which is attributable to the employees listed on the staff roster who are categorized as salaried employees. Note: Payroll tax should not apply to contracted employees. Note Also: The payroll tax calculation for salaried

employees must include a proration of the payroll tax by program for those employees assigned to multiple provider programs.

Item 13 - Health Benefits. Enter the Health Benefit costs attributable to the employees listed on the staff roster who are categorized as salaried employees. The instructions for Item 12, Payroll Tax as they relate to employees assigned to multiple programs also pertain to the calculation of Health Benefit Costs.

Item 14 - Other Fringe Benefits. Report Other Fringe Benefits using the same allocation procedures as previously described for Payroll Tax and Health Benefits.

Item 15 - Total Fringe Benefits. Sum the entries for Payroll Tax, Health Benefits, and Other Fringe Benefits and enter this sum as "Total Fringe Benefits".

Item 16 - Total Direct Staff and Fringe Benefit Costs. Add the total entered as Item 11, Total Program Direct Staff Costs, and the total entered as Item 15, Total Fringe Benefits, and enter this sum as Item 16, "Total Direct Staff and Fringe Benefit Costs".

Items 17 through 20 - Staff travel and training costs are allowable categories of cost for the proposed Program subject to certain conditions and limitations. Previous Budget Proposal instructions describe the policies applicable to this category of costs. Before budgeting costs for staff travel and training, the provider should ensure that the DSAMH policies and procedures set forth previously have been fully conformed with. Staff training and travel costs may be budgeted only for those individuals listed on the Direct Personnel Staff Roster - Item 6. Staff training costs should be prorated if other provider operated programs share or participate in proposed Program staff training events.

Item 17 - Staff Training. Enter the estimated cost of planned staff training events in the space referenced on the budget form. Staff training costs include only fees or tuition. Travel to and from the training event should be recorded as Staff Mileage, Staff Public Transportation and/or Staff Meals and Lodging costs.

Item 18 - Staff Mileage. Enter the estimated cost of staff mileage attributable to proposed Program activities.

Item 19 - Staff Public Transportation. Enter the estimated cost for use of public transportation by proposed Program staff.

Item 20 - Staff Meals and Lodging. Enter the estimated cost for staff meals and lodging which are necessitated by official Program business.

Item 21 - Total Staff Travel and Training Costs. Add the entries made for Staff Training, Staff Mileage, Staff Public Transportation and Staff Meals and Lodging and enter the total of these entries in the space provided.

Item 22 - Other Income Applied. This **column** of the budget form should be used to report other income which the provider allocates to the proposed Program.

If other income is to be applied to the proposed Program, providers should attempt to allocate these funds by cost element on the budget form.

Other income should be entered in the spaces corresponding to numbered lines and category totals applicable to the total program.

Item 23 - Anticipated Contract Costs. This **column** represents the Difference between Program Costs and Other Income Applied (Item 22).

Item 24 - Real Estate Tax/Property Insurance. Providers operating multiple programs in their building facilities must allocate the real estate tax and property insurance to the programs sharing the facilities. Your budget submission should represent only the pro rata share of these taxes and insurance which are allocable to the proposed Program.

Item 25 - Licenses, Permits and Fees. Providers operating multiple programs in their building facilities must allocate their building licenses, permits, and fee costs in this line Item. Enter only the pro rata share of these costs attributable to the proposed Program.

Item 26 - Utilities. Prorate utility costs among the programs operated by the provider which share the facility for which utility costs were billed. Report only that pro rata share of utility costs which is allocable to the proposed Program.

Item 27 - Repair and Maintenance. Allocate repair and maintenance costs for a facility to the provider programs which share that facility. Enter only the pro rata share of repair and maintenance costs which are allocable to the proposed Program.

Note: Repair and maintenance costs should not include the salary costs of provider employees who perform repair and maintenance functions. Salary costs of provider employees performing repair and maintenance functions should be considered to be an "indirect cost" for the proposed Program.

Item 28 - Rent. Allocate rental payments for building facilities to the programs sharing the facility. Enter on the budget form only the share of rental costs which are assignable to the proposed Program. [See Budget

Guidelines re: Occupancy Cost (Rental Facilities) regarding Client Rental Costs vs. Facility rental costs.]

Item 29 - Custodial Supplies. Allocate custodial supplies to the programs sharing in their usage. Enter the proposed Program's share of the cost of these custodial supplies.

Item 30 - Insurance. Allocate building insurance costs to the programs using those buildings which have been insured. Enter the proposed Program's share of the cost of the insurance.

Item 31 - Other Occupancy Costs. Providers wishing to report other occupancy costs should attach a detail sheet which defines the nature of these costs. The total of these "Other Occupancy Costs" which represents the proposed Program's pro rata share should be entered in the space provided on the budget form.

Providers who own rather than lease their buildings should use this space to report Building Depreciation Costs and Mortgage Interest Costs. Both Depreciation and Interest Costs must be allocated to the programs which share the use of the facility.

This line item in your budget submission may also be used to report any contracted occupancy related costs such as contracted housekeeping services or contracted lawn services.

Each entry you record as an "Other Occupancy Cost" should be described in more detail in a separate narrative statement which should be appended to your budget submission.

Item 32 - Total Occupancy Costs - Sum all entries made relating to Occupancy Costs (i.e., Items 24 through 31) and enter the total in the space provided.

Item 33 through Item 35 - Guidelines provided previously provide two alternative methods

for providers to expense vehicles owned by the provider. If Option #1 is selected (i.e., costing on a per mile basis), no entry should be made for Item 33 - Gas and Oil, Item 34 - Vehicle Repair and Maintenance, and Item 35 - Vehicle Insurance and Tax.

If Option #2 is selected, vehicle operating costs must be pro rated between the programs sharing the use of the vehicle. Further, the percentage of costs allocable to personal use of the vehicle must be deducted if the vehicle is used for other than official business. The same allocation methodology must be applied to each cost element (e.g., if 20 percent of Gas and Oil costs are assignable to the proposed Program, then the 20 percent allocation factor in this example would also be the proposed Program's share of vehicle repair and maintenance costs and vehicle insurance and tax costs.

Item 36 - Vehicle Lease Costs. Enter the proposed Program's share of vehicle lease costs in the space provided on the budget form.

Item 37 - Contractual Transportation. Contractual transportation costs represent the costs to rent special purpose vehicles such as a bus or a van to transport clients or staff to a location. Enter the pro rata share of these costs which are assignable to the proposed Program.

Item 38 - Public Transportation. This cost category should be used only for client public transportation costs. Staff transportation should be coded as "Staff Public Transportation" Item 19. Budget preparation guidelines presented earlier describe rules and regulations applicable to this cost element. Enter client public transportation costs in the space provided on the budget form.

Item 39 - Other Transportation Costs. Additional Program Transportation costs not classified previously on the budget form should be entered in this space. Attach a detail sheet to your budget submission which defines the nature of these costs.

Providers who own rather than lease their vehicles should use this space to report Vehicle Depreciation and Interest Costs. Both Depreciation and Interest Costs must be allocated to the programs which share the use of the vehicle.

Item 40 - Total Transportation Costs. Sum all entries made relating to Transportation Costs (i.e., Items 34 through 40) and enter the total in the space provided.

Item 41 - Food and Groceries. Enter the costs of providing food and groceries to residents of the proposed program. This cost category is applicable ONLY to specific DSAMH programs.

Item 42 - Educational Supplies. Enter the costs of providing educational supplies/materials for client education services. This cost category is applicable ONLY to specific DSAMH programs. Any cost should be fully explained in an attached detail sheet.

Item 43 - Dry Goods. Enter the cost of supplying linens, toweling, and similar items necessary to the provision of resident room and board. This cost category is applicable ONLY to specific DSAMH programs. .

Item 44 - Laundry supplies. Enter the cost of supplies used primarily for the purpose of laundering clothing, linens and related items necessary to the provision of resident room and board. This cost category is applicable ONLY to specific DSAMH programs.

Item 45 - Client Rental Assistance. Enter the cost of assisting program participants in renting a domicile separate from the proposed

program. This cost category is applicable ONLY to specific DSAMH programs.

Item 46 - Personal Care Supplies. Enter the cost of providing or assisting residents' acquisition of personal care supplies (hygienic, cosmetic and related items). This cost category is applicable ONLY to specific DSAMH program**.**

Item 47 - Other Client Assistance. Enter the cost of providing all other assistance on behalf of program participants which takes the form of cash, commodities or other gifts. This cost category is applicable ONLY to specific DSAMH programs. **Must be completely described and explained.]**

Item 48- Total Client Costs. Sum all entries made relating to client costs and enter the total in the space(s) provided.

Item 49 - Consultant Costs. Previous guidelines presented in the Budget Proposal instructions define the differences between Consultant Costs and Contracted Direct Staff. Contracted Direct Staff are to be included in the Direct Personnel Staff Roster and budgeted as a part of personnel costs. Consultant costs include professional services contracted by the provider for activities not directly related to patient care. Examples could include accounting and auditing services or management consulting services. In most instances consultant costs will benefit all programs operated by the provider. Care must be exercised in prorating the cost of consultant services to the programs that benefit from those services.

Enter the share of consultant costs which is allocated to the proposed Program in the space indicated on the budget form. **Attach a detail sheet to your budget submission that describes the nature of these consultant costs.**

Item 50 - Telephone. Cost allocation of phone charges can be averted if the phones used by proposed Program personnel are separately billed by the phone company. If phone charges cannot be isolated by provider program, then an allocation methodology must be developed to prorate expenses across all provider programs. Enter the share of telephone costs assignable to the proposed Program in the space provided on the budget form.

Item 51 - Postage. Enter the cost of postage for the proposed Program.

Item 52 - Advertising/Recruiting. Advertising, except for the purposes of recruiting staff, is not an allowable cost. Enter advertising costs on your budget form only if it is for the purpose of recruiting proposed Program staff.

Item 53 - Printing and Reproduction. Enter the cost of printing and reproducing proposed Program materials.

Item 54 - Office Supplies. Office supplies for the proposed Program should be stored and maintained in the proposed Program work space to prevent the commingling of these items with office supplies for other programs. Enter the cost of office supplies for proposed Program functions.

Item 55 - Equipment Rental. Equipment rental contracts should be executed on a program by program basis to avoid commingling of equipment between programs. A copy of the equipment rental agreements for the proposed Program should be maintained on site for periodic review by DSAMH personnel. Enter in the space provided on the budget form the total of equipment rental contracts for the proposed Program.

Item 56 - Equipment Repair/Maintenance. Enter the cost of equipment repair and maintenance for proposed Program equipment.

Item 57 - Other Operating Costs. Cost elements which could not be classified elsewhere as an operating cost should be entered in this budget line. **A detailed description of the items budgeted for this cost category must be attached to the budget form.**

Item 58 - Enter the cost of any requested equipment and/or other capital expenditures requested. As per guidelines and instructions presented previously, such expenses are not allowable for some programs using a unit-rate payment mechanism (although interest and depreciation are allowable). Attach a detailed listing, including justification, of proposed equipment and capital purchases requested as cost-reimbursable items. [This item is generally allowable with regard to the program sought under PSC - 0733].

Item 59 - Total Operating Costs. Sum all entries made relating to operating expenses (i.e., Items 49 through 59) and enter the total in the space provided.

Item 60 - Total Direct Program Costs. Total Direct Program Costs are the sum of:

- Total Direct Personnel and Fringe Benefit Costs (Item 16)
- Total Staff Travel and Training Costs (Item 21)
- Total Occupancy Costs (Item 32)
- Total Transportation Costs (Item 40)

- Total Client Costs (Item 48)

- Total Operating Costs (Item 59).

Sum the entries for each of these subtotals and enter the amount in the space provided for Item 60.

Item 61 - Allocation of Indirect Costs. Discussion of indirect costs presented previously describes the procedures for creating an Indirect Cost Pool and allocating the Indirect Cost Pool to the individual programs operated by the provider.

Providers operating multiple programs must calculate their Indirect Cost allocation to the proposed Program. These providers should then multiply their Total Direct Program Cost (Item 60) on the budget worksheet by (12.0 percent). The lesser of 12.0 percent of Total Direct Program Costs or the calculated share of Indirect Costs assignable to the proposed Program should be entered as the provider's indirect cost.

Item 62 - Total Program Cost. Add Total Direct Program Costs (Item 60) and the Allocation of Indirect Cost (Item 61) and enter this sum in the space indicated. This number is the amount of funds you expect to require in order to operate the total program for the budget period (Item 5).

Item 63 - Total Other Income Applied. Item 22 instructions for the budget requested that providers identify other income that will be provided to the proposed Program. Enter the Total of other income to be applied to the program in the space indicated for Item 63.

Item 64 - Total DSAMH Contract Request. Enter the difference between Total Program Cost (Item 62) and the Total Other Income Applied (Item 63). This represents the Contract amount which is being requested from DSAMH in support of the budgeted Program for the budget period (Item 5).

Item 65 - Other Sources of Income. The sources of any Other Income to be applied (Item 63) must be specified. The amount anticipated from each source must be estimated.

Contract Boiler Plate

A) Introduction

1. This contract is entered into between the Delaware Department of Health and Social Services (the Department), Division of _____ (Division) and _____(the Contractor).

2. The Contract shall commence on _____ and terminate on _____ unless specifically extended by an amendment, signed by all parties to the Contract. Time is of the essence. (Effective contract start date is subject to the provisions of Paragraph C 1 of this Agreement.)

B) Administrative Requirements

1. Contractor recognizes that it is operating as an independent Contractor and that it is liable for any and all losses, penalties, damages, expenses, attorney's fees, judgments, and/or settlements incurred by reason of injury to or death of any and all persons, or injury to any and all property, of any nature, arising out of the Contractor's negligent performance under this Contract, and particularly without limiting the foregoing, caused by, resulting from, or arising out of any act of omission on the part of the Contractor in their negligent performance under this Contract.

2. The Contractor shall maintain such insurance as will protect against claims under Worker's Compensation Act and from any other claims for damages for personal injury, including death, which may arise from operations under this Contract. The Contractor is an independent contractor and is not an employee of the State.

3. During the term of this Contract, the Contractor shall, at its own expense, carry insurance with minimum coverage limits as follows:

a) Comprehensive General Liability $1,000,000
and
b) Medical/Professional Liability $1,000,000/ $3,000,000

or c) Misc. Errors and Omissions $1,000,000/$3,000,000

or d) Product Liability $1,000,000/$3,000,000

All contractors must carry (a) and at least one of (b), (c), or (d), depending on the type of service or product being delivered.

If the contractual service requires the transportation of Departmental clients or staff, the contractor shall, in addition to the above coverage, secure at its own expense the following coverage:

e) Automotive Liability (Bodily Injury) $100,000/$300,000
f) Automotive Property Damage (to others) $ 25,000

4. Not withstanding the information contained above, the Contractor shall indemnify and hold harmless the State of Delaware, the Department and the Division from contingent liability to others for damages because of bodily injury, including death, that may result from the Contractor's negligent performance under this Contract, and any other liability for damages for which the Contractor is required to indemnify the State, the Department and the Division under any provision of this Contract.

5. The policies required under Paragraph B3 must be written to include Comprehensive General Liability coverage, including Bodily Injury and Property damage insurance to protect against claims arising from the performance of the Contractor and the contractor's subcontractors under this Contract and Medical/Professional Liability coverage when applicable.

6. The Contractor shall provide a Certificate of Insurance as proof that the Contractor has the required insurance. The certificate shall identify the Department and the Division as the "Certificate Holder" and shall be valid for the contract's period of performance as detailed in Paragraph A 2.

7. The Contractor acknowledges and accepts full responsibility for securing and maintaining all licenses and permits, including the Delaware business license, as applicable and required by law, to engage in business and provide the goods and/or services to be acquired under the terms of this Contract. The Contractor acknowledges and is aware that Delaware law provides for significant penalties associated with the conduct of business without the appropriate license.

8. The Contractor agrees to comply with all State and Federal licensing standards and all other applicable standards as required to provide services under this Contract, to assure the quality of services provided under this Contract. The Contractor shall immediately notify the Department in writing of any change in the status of any accreditations, licenses or certifications in any jurisdiction in which they provide services or conduct business. If this change in status regards the fact that its accreditation, licensure, or certification is suspended, revoked, or otherwise impaired in any jurisdiction, the Contractor understands that such action may be grounds for termination of the Contract.

9. Contractor agrees to comply with all the terms, requirements and provisions of the Civil Rights Act of 1964, the Rehabilitation Act of 1973 and any other federal, state, local or any other anti discriminatory act, law, statute, regulation or policy along with all amendments and revision of these laws, in the performance of this Contract and will not discriminate against any applicant or employee or service recipient because of race, creed, religion, age, sex, color, national or ethnic origin, disability or any other unlawful discriminatory basis or criteria.

10. The Contractor agrees to provide to the Divisional Contract Manager, on an annual basis, if requested, information regarding its client population served under this Contract by race, color, national origin or disability.

11. This Contract may be terminated in whole or part:

a) by the Department upon five (5) calendar days written notice for cause or documented unsatisfactory performance,

b) by the Department upon fifteen (15) calendar days written notice of the loss of funding or reduction of funding for the stated Contractor services as described in Appendix B,

c) by either party without cause upon thirty (30) calendar days written notice to the other Party, unless a longer period is specified in Appendix A.

In the event of termination, all finished or unfinished documents, data, studies, surveys, drawings, models, maps, photographs, and reports or other material prepared by Contractor under this contract shall, at the option of the Department, become the property of the Department.

In the event of termination, the Contractor, upon receiving the termination notice, shall immediately cease work and refrain from purchasing contract related items unless otherwise instructed by the Department.

The Contractor shall be entitled to receive reasonable compensation as determined by the Department in its sole discretion for any satisfactory work completed on such documents and other materials that are usable to the Department. Whether such work is satisfactory and usable is determined by the Department in its sole discretion.

Should the Contractor cease conducting business, become insolvent, make a general assignment for the benefit of creditors, suffer or permit the appointment of a receiver for its business or assets, or shall avail itself of, or become subject to any proceeding under the Federal Bankruptcy Act or any other statute of any state relating to insolvency or protection of the rights of creditors, then at the option of the Department, this Contract shall terminate and be of no further force and effect. Contractor shall notify the Department immediately of such events.

12. Any notice required or permitted under this Contract shall be effective upon receipt and may be hand delivered with receipt requested or by registered or certified mail

with return receipt requested. Either Party may change its address for notices and official formal correspondence upon five (5) days written notice to the other.

13. In the event of amendments to current Federal or State laws which nullify any term(s) or provision(s) of this Contract, the remainder of the Contract will remain unaffected.

14. This Contract shall not be altered, changed, modified or amended except by written consent of all Parties to the Contract.

15. The Contractor shall not enter into any subcontract for any portion of the services covered by this Contract without obtaining prior written approval of the Department. Any such subcontract shall be subject to all the conditions and provisions of this Contract. The approval requirements of this paragraph do not extend to the purchase of articles, supplies, equipment, rentals, leases and other day-to-day operational expenses in support of staff or facilities providing the services covered by this Contract.

16. This entire Contract between the Contractor and the Department is composed of these several pages and the attached:

Appendix A - Divisional Requirements

Appendix B - Services Description

Appendix C - Contract Budget

Appendix …….

17. This Contract shall be interpreted and any disputes resolved according to the Laws of the State of Delaware. Except as may be otherwise provided in this contract, all claims, counterclaims, disputes and other matters in question between the Department and Contractor arising out of or relating to this Contract or the breach thereof will be decided by arbitration if the parties hereto mutually agree, or in a court of competent jurisdiction within the State of Delaware.

18. In the event Contractor is successful in an action under the antitrust laws of the United States and/or the State of Delaware against a vendor, supplier, subcontractor, or other party who provides particular goods or services to the Contractor that impact the budget for this Contract, Contractor agrees to reimburse the State of Delaware, Department of Health and Social Services for the pro-rata portion of the damages awarded that are attributable to the goods or services used by the Contractor to fulfill the requirements of this Contract. In the event Contractor refuses or neglects after reasonable written notice by the Department to bring such antitrust action, Contractor shall be deemed to have assigned such action to the Department.

19. Contractor covenants that it presently has no interest and shall not acquire any interests, direct or indirect, that would conflict in any manner or degree with the

performance of this Contract. Contractor further covenants that in the performance of this contract, it shall not employ any person having such interest.

20. Contractor covenants that it has not employed or retained any company or person who is working primarily for the Contractor, to solicit or secure this agreement, by improperly influencing the Department or any of its employees in any professional procurement process; and, the Contractor has not paid or agreed to pay any person, company, corporation, individual or firm, other than a bona fide employee working primarily for the Contractor, any fee, commission, percentage, gift or any other consideration contingent upon or resulting from the award or making of this agreement. For the violation of this provision, the Department shall have the right to terminate the agreement without liability and, at its discretion, to deduct from the contract price, or otherwise recover, the full amount of such fee, commission, percentage, gift or consideration.

21. The Department shall have the unrestricted authority to publish, disclose, distribute and otherwise use, in whole or in part, any reports, data, or other materials prepared under this Contract. Contractor shall have no right to copyright any material produced in whole or in part under this Contract. Upon the request of the Department, the Contractor shall execute additional documents as are required to assure the transfer of such copyrights to the Department.

    If the use of any services or deliverables is prohibited by court action based on a U.S. patent or copyright infringement claim, Contractor shall, at its own expense, buy for the Department the right to continue using the services or deliverables or modify or replace the product with no material loss in use, at the option of the Department.

22. Contractor agrees that no information obtained pursuant to this Contract may be released in any form except in compliance with applicable laws and policies on the confidentiality of information and except as necessary for the proper discharge of the Contractor's obligations under this Contract.

23. Waiver of any default shall not be deemed to be a waiver of any subsequent default. Waiver or breach of any provision of this Contract shall not be deemed to be a waiver of any other or subsequent breach and shall not be construed to be a modification of the terms of the Contract unless stated to be such in writing, signed by authorized representatives of all parties and attached to the original Contract.

24. If the amount of this contract listed in Paragraph C2 is over $100,000, the Contractor, by their signature in Section E, is representing that the Firm and/or its Principals, along with its subcontractors and assignees under this agreement, are not currently subject to either suspension or debarment from Procurement and Non-Procurement activities by the Federal Government.

C) Financial Requirements

1. The rights and obligations of each Party to this Contract are not effective and no Party is bound by the terms of this contract unless, and until, a validly executed Purchase Order is approved by the Secretary of Finance and received by Contractor, *if required by the State of Delaware Budget and Accounting Manual***,** and all policies and procedures of the Department of Finance have been met. The obligations of the Department under this Contract are expressly limited to the amount of any approved Purchase Order. The State will not be liable for expenditures made or services delivered prior to Contractor's receipt of the Purchase Order.

2. Total payments under this Contract shall not exceed $ _____ in accordance with the budget presented in Appendix C. Payment will be made upon receipt of an itemized invoice from the Contractor in accordance with the payment schedule, if any. The contractor or vendor must accept full payment by procurement (credit) card and or conventional check and/or other electronic means at the State's option, without imposing any additional fees, costs or conditions. Contractor is responsible for costs incurred in excess of the total cost of this Contract and the Department is not responsible for such costs.

3. The Contractor is solely responsible for the payment of all amounts due to all subcontractors and suppliers of goods, materials or services which may have been acquired by or provided to the Contractor in the performance of this contract. The Department is not responsible for the payment of such subcontractors or suppliers.

4. The Contractor shall not assign the Contract or any portion thereof without prior written approval of the Department and subject to such conditions and revisions as the Department may deem necessary. No such approval by the Department of any assignment shall be deemed to provide for the incurrence of any obligations of the Department in addition to the total agreed upon price of the Contract.

5. Contractor shall maintain books, records, documents and other evidence directly pertinent to performance under this Contract in accordance with generally accepted accounting principles and practices. Contractor shall also maintain the financial information and data used by Contractor in the preparation of support of its bid or proposal. Contractor shall retain this information for a period of five (5) years from the date services were rendered by the Contractor. Records involving matters in litigation shall be retained for one (1) year following the termination of such litigation. The Department shall have access to such books, records, documents, and other evidence for the purpose of inspection, auditing, and copying during normal business hours of the Contractor after giving reasonable notice. Contractor will provide facilities for such access and inspection.

6. The Contractor agrees that any submission by or on behalf of the Contractor of any claim for payment by the Department shall constitute certification by the Contractor that the services or items for which payment is claimed were actually rendered by the Contractor or its agents, and that all information submitted in support of the claims is true, accurate, and complete.

7 The cost of any Contract audit disallowances resulting from the examination of the Contractor's financial records will be borne by the Contractor. Reimbursement to the Department for disallowances shall be drawn from the Contractor's own resources and not charged to Contract costs or cost pools indirectly charging Contract costs.

8. When the Department desires any addition or deletion to the deliverables or a change in the services to be provided under this Contract, it shall so notify the Contractor. The Department will develop a Contract Amendment authorizing said change. The Amendment shall state whether the change shall cause an alteration in the price or time required by the Contractor for any aspect of its performance under the Contract. Pricing of changes shall be consistent with those prices or costs established within this Contract. Such amendment shall not be effective until executed by all Parties pursuant to Paragraph B 14.

D) Miscellaneous Requirements

1. *If applicable*, the Contractor agrees to adhere to the requirements of DHSS Policy Memorandum # 46, (PM # 46, effective 5/23/97), and divisional procedures regarding the reporting and investigation of suspected abuse, neglect, mistreatment, misappropriation of property and significant injury of residents/clients receiving services. The policy and procedures are included as Appendix _____ to this Contract. It is understood that adherence to this policy includes the development of appropriate procedures to implement the policy and ensuring staff receive appropriate training on the policy requirements. The Contractor's procedures must include the position(s) responsible for the PM46 process in the provider agency. Documentation of staff training on PM46 must be maintained by the Contractor.

2. The Contractor, including its parent company and its subsidiaries, and any subcontractor, including its parent company and subsidiaries, agree to comply with the provisions of 29 Del. Code, Chapter 58: "Laws Regulating the Conduct of Officers and Employees of the State," and in particular with Section 5805 (d): "Post Employment Restrictions."

3. *When required by Law*, Contractor shall conduct child abuse and adult abuse registry checks and obtain service letters in accordance with 19 Del. Code Section 708; and 11 Del. Code, Sections 8563 and 8564. Contractor shall not employ individuals with adverse registry findings in the performance of this contract.

E) Authorized Signatures:

For the Contractor:

_____
Name

_____
Title

_____
Date

For the Department:

_____
Vincent P. Meconi
Secretary

_____
Date

For the Division:

_____

Director

_____
Date

ATTACHMENT 5

Level Of Care Utilization System for Psychiatric and Addiction Services

Electronic Format is available at http://www.state.de.us/dhss/rfp/dhssrfp.htm

Copies will be distributed at the Mandatory Pre-Submission Meeting

ATTACHMENT 6

Residential Treatment for Substance Abuse Licensing Standards

Copies will be distributed at the Mandatory Pre-Submission Meeting

State of Delaware
Department of Health and Social Services

August 6, 2002

POLICY MEMORANDUM NUMBER: 24

Subject: Safeguarding and Management of Resident/Client Funds

I. PURPOSE

To establish guidelines that provides accountability for property and the management, receipt, and disbursement of each resident/client's funds. Furthermore, this policy should provide direction to the respective divisions for the development and implementation of internal policies on this subject; however; no part of this departmental policy may be voided.

II. POLICY

In an effort to support resident/client independence and self management, the Department of Health and Social Services (DHSS) shall safeguard and help manage the personal property and finances of those residents/clients housed and cared for in state operated programs or programs operated by a contracted provider.

III. APPLICABILITY

This policy applies to all individuals receiving residential, day program or outpatient services from the Department of Health and Social Services or contracted provider.

IV. ENFORCEMENT

Any person involved in misappropriations of a residents/clients funds or property shall be subject to disciplinary action within DHSS. In addition, the person is subject to criminal prosecution in accordance with Title 11 Del. C. § 841(c)(2)(3)(a)(b).

V. DEFINITIONS

A. Co-mingling of Individual Funds: The blending of the funds of an individual receiving services with the funds of any DHSS employee/agency. Co-mingling is strictly prohibited.

B. Community Bank Account: An account established at a financial institution in the community for DHSS resident/client who receive residential, day program or outpatient services.

C. Department: Refers to Delaware Health and Social Services herein known as "DHSS", as an entity including all Divisions and the Office of the Secretary.

D. Division: An agency within the Delaware of Health and Social Services.

E. Division Management: Employees who exercise executive, administrative, and supervisory direction within the division.

F. Individual: Resident/Client

G. Medicaid: A federal assistance program that is administered by the states. Eligibility is based upon financial need, disability or age. Components of the program include:

1. Health insurance signified by the Medicaid card, that includes hospital and medical coverage based upon Supplemental Security Income benefits, vendor payment or Home and Community based waiver services eligibility.

2. Vendor payments are monthly payments to skilled and intermediate care facilities meeting Medicaid program standards.

3. Home and community based Medicaid waiver services.

H. Misappropriation of Property or Funds: Theft of an individual's money or property; use of an individual's money or property without permission of the individual, guardian or representative payee; acceptance by staff of an individual's money or property regardless of permission; and mishandling of an individual's money or property.

I. Organizational Representative Payee: The organization authorized by the payer of the benefit to receive benefit payments on behalf of the individual receiving services. Division management shall be responsible for providing supervision and direction in the management of benefit programs and funds.

J. Personal Property: Property other than real property, consisting of things temporary or moveable.

K. Personal Spending Record: An approved form/system used to record in-house funds maintained in the provider's home or a residential placement for the individual to use. The form tracks deposits and withdrawals to the in-house account, including the source of deposits and reasons for withdrawals.

L. Provider: A person or organization under contract and certified with any division within the DHSS as having met the standards set forth by the division and any other licensing requirements.

M. Resources: The financial assets of an individual including:

1. Earned Income: The income received from gross wages or net earnings from employment.

2. Unearned Income: the income received from sources that include, but are not limited to: Social Security, Supplemental Security Income, Workers' or Veterans' compensation, support and maintenance in kind, annuities, rent, interests, trusts, stocks, pensions, dividends, bonds, and/or mutual funds.

N. Social Security Administration (SSA): The federal agency that administers and reviews the eligibility and uses of Social Security and Supplemental Security Income benefits.

VI. RESPONSIBILITY

A. Procedure:

If an employee of DHSS or contracted provider has been accused of misappropriation of resident/client funds or property, the employee shall be removed from direct contact with the resident/client. The division shall begin a detailed investigation in accordance with the Department Policy Memorandum #46 and initiate a criminal investigation by contacting the appropriate law enforcement agencies. The determination as to whether to prosecute shall be made by the law enforcement agencies.

The division director will provide leadership and assume overall responsibility for assuring policy observance.

Each division that is responsible for resident/client care shall develop or review existing division policy that discusses the day to day management of the resident's/client's monies, and inventory control of resident's/client's personal property. The standards set forth in section VII below shall be implemented into the division policy. A copy of the Division's policy should be forwarded to the Chief Policy Advisor, in the Office of the Secretary and the Director of the Division of Management Services (DMS).

B. Reimbursement:

The division/provider shall be responsible for ensuring reimbursement to any DHSS resident/client who receives residential, day program or outpatient services for any missing, stolen, and/or unaccounted funds and/or property that have been determined to be misappropriated. Reimbursement shall be made after a thorough investigation and documented findings. The investigation and findings shall be completed within ninety (90) days after the reporting of the alleged misappropriation to division management. A report of such findings, along with reimbursement documentation, shall be forwarded to MS.

The division director shall communicate to the Office of the Attorney General when reimbursement has been made to the resident/client by the state. If the person is found criminally responsible for the theft, any court ordered restitution should be paid to the Department.

The division director shall consult the appropriate personnel if a misappropriation of funds or property by one resident/client against another resident/client is believed to have occurred. Reimbursement to the resident/client shall be made, and restitution to the state will occur if appropriate.

VII. **STANDARDS**:

- **General**

A. To promote self-sufficiency, the division shall advocate and recognize the right of each individual to manage his/her own money and finances. Each individual's Interdisciplinary Team will assess the individual's capabilities to manage his/her own benefits, money and property.

B. The division shall offer and provide organizational representative payee services under the following conditions:

1. There is evidence that the DHSS resident/client who receives residential, supported-living or outpatient service is not capable of managing or directing the management of benefit payments in his or her own best interest, or;

2. The individual has a legal guardian and the guardian chooses to relinquish the responsibility to the respective Division.

C. Once selected as the organizational representative payee, the division will provide assistance and support to individuals unable to manage their own finances.

D. The division management shall reserve the right to terminate the responsibility of serving as the organizational representative payee for the following reasons:

1. Intentional falsification of information regarding all resources and assets by the resident/client receiving services, a family member acting on the individual's behalf, an advocate, or guardian.

2. Refusal by the resident/client to provide financial information or evidence when requested by the department, Social Security Administration, or Medicaid. Financial information or evidence for individuals ages 18 years or older shall be limited to

resources and/or assets established under the individual's social security number.

3. The resident/client is no longer receiving benefits or has been discharged from the division.

Note- Termination of such responsibility releases the division from future claims arising from such resident/client.

E. A resident's/client's funds shall not be expended for goods and services that the state/provider is required to provide according to the Social Security Administration and Medicaid guidelines. The division shall not spend a resident's/client's funds in a way that would leave him or her without necessary items or services (housing, food, clothing, medical care).

F. Employees shall not borrow from or lend money to an individual receiving services. Employees are also prohibited from co-owning and or/ co-signing with the resident/client. Only in circumstances where the division has been designated the organizational representative payee shall the employee act as a custodian of any bank account of an individual receiving services.

G. Employee shall not sell goods and/or services to an individual receiving services from the Division.

- **Audits:**

. On a quarterly basis, the division shall perform random audits of at least 15% of their resident's/client's personal spending records in which the division serves as the representative payee. The results of the audits will be summarized and reviewed with the division director and facility director quarterly.

A. Divisions shall receive audits from the Social Security Administration, State Auditor's Office, and the Division of Management Services (DMS), Revenue Management Unit. Divisions shall be responsible for completing an annual accounting of each resident/client's benefits via the filing of various reports.

B. Contract provider agencies shall be required to conduct an independent annual professional audit of the resident/client funds that shall be submitted to the division prior to the end of each fiscal year. Audit findings shall be reviewed with division management.

C. Contract provider agencies shall be required to develop and submit internal policies and procedures regarding resident/client funds management to the division management or said designee. The policies/procedures submitted shall meet the standards within this policy.

- **Resident/Client Accounts**

. The division shall establish and maintain a system that assures a full and complete accounting of each resident's/client's personal funds entrusted to the organization/agency and precludes any co-mingling of resident's/client's funds with the division's funds or with the funds of any DHSS employee.

A. If appropriate, the division shall ensure that guidelines are in place for residents /clients residing in community living arrangements and participating in a division's organizational representative payee program to establish community bank accounts. The accounts shall be opened within 30 days of residential placement. The account will be titled to the individual receiving services (when appropriate) and generate a monthly statement, which includes cancelled checks (if applicable).

B. In cases where financial institutions will not permit the resident/client to open an account in his/her own name due to the individual's inability to contract for business, the division will review the resident/clients circumstances on a case by case basis to best determine the resident's/client's needs.

C. Providers shall not be permitted to close a resident's/client's community bank account without the written approval of the authorized division management. Management shall document the approval to close an account.

- **Monitoring/Safeguarding Resident/Client Funds:**

. Division management shall be responsible for coordinating and monitoring oversight of all financial matters for the resident/client for whom the division/provider have been designated as representative payee.

A. Division management shall be responsible for establishing guidelines for expenditure authorization and approval, including conducting quarterly reviews. Any discrepancies exceeding $100 per incident shall be reported to the DMS Budget & Program Analysis Unit.

VIII. IMPLEMENTATION

. This revised policy memorandum is effective August 6, 2002.

A. This Department Policy supersedes all other polices, directives, or rules related to the subject.

B. Divisions shall take the necessary action to create their own policy on this subject and review for possible changes on an annual basis.

Vincent P. Meconi
Vincent P. Meconi, Secretary

ATTACHMENT 8

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

LONG TERM CARE SYSTEM

ELIGIBILITY AND ENROLLMENT UNIT PROCEDURES

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DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH
LONG TERM CARE SYSTEM

ELIGIBILITY AND ENROLLMENT UNIT PROCEDURES

I. CLINICAL ELIGIBILITY DETERMINATION

The Division of Substance Abuse and Mental Health (DSAMH) LTC system serves adults (age 18 years and older) with severe and persistent behavioral health disorders who meet disability, duration of illness and diagnostic criteria. The LTC System provides services for: individuals enrolled in Medicaid; individuals with dual eligibility of Medicaid and Medicare; individuals with Medicare only coverage; individuals without insurance coverage; and those with limited insurance coverage.

Clinical eligibility for and enrollment into the DSAMH Long Term Care (LTC) system will be determined by the DSAMH Eligibility and Enrollment Unit (EEU). The EEU will process all applications for enrollment into the DSAMH LTC System.

Clinical Eligibility Criteria for Enrollment into the DSAMH LTC System

- are age 18 years and older; and
- are U.S. citizens or have a legal resident alien status; and
- are residents of the State of Delaware; and
- are determined to have a specific primary DSM-IV diagnosis as listed below (Eligible Mental Illness Diagnoses and Eligible Substance Abuse Diagnoses) that has resulted in functional impairment which substantially interferes with or limits one or more major life activities [as determined by a formal DSAMH EEU review of the clinical information submitted in a complete **Enrollment Application Form**]; and
- present a history of having received intensive behavioral health treatment in one or more community or institutional programs including: Delaware Psychiatric Center; DSAMH Continuous Treatment Team programs; group homes, and long-term residential substance abuse treatment facilities; and/or
- present a history of having had multiple alcohol and other drug detoxification admissions and/or multiple intensive substance abuse treatment episodes.

Special eligibility determinations will be made for adults with developmental disabilities/mental retardation who have a severe and persistent behavioral health disorders and are in the upper mild range of mental retardation (317.0).

All individuals meeting the clinical eligibility criteria will be enrolled in the DSAMH LTC system.

Eligible Mental Illness Diagnoses

Schizophrenia and Other Psychotic Disorders

295.10 - Disorganized Type
295.20 - Catatonic Type
295.30 - Paranoid Type
295.40 - Schizophreniform Disorders
295.60 - Residual Type
295.70 - Schizoaffective Disorders
295.90 - Undifferentiated Type
297.10 - Delusional Disorders

Mood Disorders

Major Depressive Disorders, Recurrent
296.30 - Unspecified
296.32 - Moderate
296.33 - Severe Without Psychotic Features
296.34 - Severe With Psychotic Features

Bipolar Disorders

296.40 - Bipolar I Disorders, Most Recent Episode Hypomanic
296.50 - Bipolar I Disorders, Most Recent Episode Manic
296.60 - Bipolar I Disorders, Most Recent Episode Mixed, Unspecified
296.70 - Bipolar I Disorders, Most Recent Episode Unspecified
296.80 - Bipolar Disorders NOS
296.89 - Bipolar Disorders II

Personality Disorders

301.00 - Paranoid Personality Disorders
301.22 - Schizotypal Personality Disorders
301.83 - Borderline Personality Disorders

Eligible Substance Dependence Diagnoses

303.90 - Alcohol Dependence
304.00 - Opioid Dependence
304.10 - Sedative, Hypnotic or Anxiolytic Dependence
304.20 - Cocaine Dependence
304.80 - Polysubstance Dependence
304.90 - Other (or unknown) Substance Dependence; Phencyclidine Dependence

Clinical Eligibility Exclusions

DSAMH LTC services will not be available for:

- Adults with the following DSM-IV developmental disabilities/mental retardation diagnoses: 318.0 (Moderate Mental Retardation); 318.1 (Severe Mental Retardation); 318.2 (Profound Mental Retardation); and 319.0 (Mental Retardation, Severity Unspecified); and

- Adults with DSM-IV diagnoses not listed as eligible.

Requests for a clinical eligibility determination should be submitted on a consumer's/client's behalf by any Managed Care Organization (MCO) participating in the Diamond State Health Plan (DSHP) or by a behavioral health provider currently treating the consumer/client. The referral process will remain the same for all organizations submitting a request for a clinical eligibility determination and enrollment. The documentation for a clinical eligibility determination is independent from the financial eligibility determination for Medicaid, Medicare and other third party insurance liability. Financial eligibility determination for Medicaid will be performed by the DHSS/Division of Social Services (DSS).

The requesting MCO or behavioral health organization must provide full documentation regarding medical necessity when applying for a consumer's/client's clinical eligibility determination for and enrollment in the DSAMH LTC system. This will include full documentation regarding the consumer's/client's utilization of behavioral health services prior to the request for clinical eligibility determination.

The requesting organization must complete the **Enrollment Application Form** and submit it to the Director of the EEU. The requesting organization will ensure that all information needed to make a timely decision for a clinical eligibility determination will be provided to the EEU. In addition to submitting the **Enrollment Application Form**, the requesting organization must designate a Clinical Liaison to serve as a point of contact regarding issues of referral.

The EEU will review the referral packet for completeness and quality. Incomplete packets will be returned to the referring organization for completion within two (2) working days of DSAMH's receipt of the incomplete application.

Upon receipt of a complete referral packet, the EEU will evaluate the clinical documentation provided, complete an **Eligibility Determination Review** and make a determination as to the consumer's/client's eligibility for the DSAMH LTC system within five (5) working days of receipt of the complete application.

The EEU will provide written notification to the referring organization and the consumer/client of the results of its eligibility determination within two (2) working days of the review's completion. Notification to the referring organization will include a copy of the **Eligibility Determination Summary**.

II. DETERMINATION DENIALS AND APPEALS

In cases where DSAMH determines that a consumer/client does not meet eligibility criteria and denies enrollment into DSAMH's LTC system, the denial will be made by an EEU physician. The EEU will issue a denial letter to the referring organization and the consumer/client; the denial letter will include an explanation for the denial and recommendations for more effective services or additional follow-up behavioral health care service provision by the referring organization.

If the provider or the consumer/client chooses to appeal the decision, a written appeal must be filed with the DSAMH Deputy Director or designee within five (5) working days of the notification of determination. DSAMH will issue a response to an appeal within five (5) working days of receiving it. An enrollment denial upheld on appeal is subject to a second level appeal. For Medicaid enrolled consumers/clients, the second level appeal will be heard by the Division of Social Services.

III. ENROLLMENT

When the EEU makes a positive determination of eligibility, the consumer/client will be enrolled in the DSAMH LTC System within ten (10) working days of the date of written notification to the referring organization and the consumer of eligibility determination. For Medicaid recipients, the EEU will indicate the "SPI Flag" in the Medicaid Management Information System (MMIS) on the consumer's enrollment date. The EEU will also enter each consumer in the DSAMH EEU Client Tracking System and will establish a re-determination date in the System.

EEU will coordinate with the enrollee and his/her current behavioral health services provider to effect a transfer of care to a DSAMH Long Term Care Primary Service Provider (PSP). Enrolled consumers whose DSHP behavioral health provider is also a DSAMH Long Term Care provider will have the choice of remaining with his/her current provider. Consumers who are not engaged with a behavioral health provider at the time of enrollment, or those whose provider is not funded by DSAMH, will be referred to a DSAMH Long Term Care provider. In either case, the EEU will link the consumer to a Primary Service Provider. The EEU will identify the PSP based on the consumer's residence and will confirm the PSP's available service capacity through the **Long Term Care Service Inventory** which it maintains. Consumers' preferences regarding providers will be taken into account in this process. The EEU will not refer to a PSP which has no available service openings.

In coordinating the transfer of care, EEU staff will meet as needed to identify specific provider(s) to whom each consumer is to be referred. A designated EEU staff member will be assigned to each consumer and will call the identified provider to refer the consumer and will confirm the provider's tentative acceptance of each consumer within three (3) working days of written eligibility determination contained in the notification letter to the referring organization and consumer. After receiving this confirmation of the provider's tentative acceptance of the consumer, the EEU will fax the consumer's **Enrollment Application Form**

to the provider. The EEU will also fax the Unit's **Eligibility Determination Summary** to the identified provider, if the provider had not already received the **Summary** during the eligibility notification process. The EEU will also notify the referring organization as to the consumer's new primary behavioral health provider. If the provider to whom the EEU has referred the consumer believes that they are unable to appropriately serve the consumer, the provider will call the designated EEU staff member with this information. If the EEU agrees with the provider's determination, they will identify another Long Term Care provider to serve the consumer.

The provider must make concerted efforts to locate the consumer and must arrange for an initial scheduled contact which will occur within six (6) days after the provider has accepted the consumer. The provider then completes the referral process by submitting the CRF to DSAMH within twenty four (24) hours of this first scheduled contact. Providers must call the designated EEU staff member on the day they contact the consumer to confirm this contact. If a provider has not called to confirm contact with the consumer, the designated EEU staff member will call that provider to determine the consumer's status. If the provider has not located the consumer, the provider will outline the outreach and engagement activities they intend to undertake to effect linkage with the consumer. EEU staff member will then follow-up with the provider in ten (10) working days to determine whether linkage has occurred. If linkage has occurred, treatment will continue; if it hasn't, the EEU will notify the referring organization that service linkage has not occurred and will enroll the client on an 'inactive status'. The provider must make ongoing efforts to locate the consumer and make weekly progress reports to the designated EEU staff member. The client's status will be re-evaluated at ninety (90) days.

If, during the outreach process, a consumer indicates that he/she does not want to receive services from the identified provider, that provider will call the designated EEU staff person with this information. The EEU staff and the provider will review the engagement activities which were undertaken and determine whether the consumer will be referred to another provider, or to another level of service.

Authorization of Substance Abuse Services

Providers accepting consumers enrolled in the LTC System must request service authorization as required by current Division policy. For LTC consumers, the Screening and Evaluation Team may accept the ASI that is submitted as part of the **Enrollment Application Form** and use it to confirm appropriate placement.

Authorization of Mental Health Services
The Division's current system for authorization of Continuous Treatment Team and group home services will continue.

IV. UTILIZATION REVIEW

An enrollee's continued eligibility for the DSAMH LTC system will be monitored by the EEU. The EEU will analyze utilization patterns on an individual and

aggregate basis for all enrollees and will identify enrollees whose utilization appear low given the individual's identified clinical needs at enrollment. When the EEU has identified under-utilizing consumers, it will ask the provider to submit a **Consumer Status Review** so that the EEU can work with the provider to analyze reasons for low service utilization; evaluate the provider's response to the consumer's use of service; and determine additional outreach activities which may be required.

The EEU will conduct sample chart reviews to review enrollees' clinical status, treatment, rehabilitation and support service needs and receipt of such services. All service utilization and provision will be assessed in terms of progressing toward recovery goals. The EEU will also review the "Days Lapse Report" to monitor consumers' active service connection.

The EEU will notify the Primary Service Provider when it identifies consumers who have either not engaged in treatment or who appear to be withdrawing from treatment. When the EEU identifies an enrollee as potentially able to be disenrolled from the LTC system, it will conduct a clinical review with the Primary Service Provider to assess the individual's self-care potential and recovery status.

V. TRANSFERS BETWEEN LONG TERM CARE PROVIDERS

If a consumer wishes to transfer from one LTC provider to another, the provider will call the Office of Consumer Affairs who will work with the consumer and provider to develop a clinically sound plan. When the plan is finalized, if the consumer is to transfer to another provider, the provider will notify the EEU who will follow the relevant enrollment procedures in Section III.

VI. ANNUAL ELIGIBILITY RE-DETERMINATION

The EEU will establish a system for monitoring the anniversary dates for enrollees and will conduct re-determination reviews of all DSHP LTC enrollees on an annual basis.

As part of the re-determination process, the Primary Service Provider will be required to submit an abbreviated, updated **Enrollment Application Form** ("short form") for review by the EEU. As a result of the re-determination review, the EEU will either confirm the enrollee's continued eligibility or disenroll the individual from the DSAMH LTC system. If the consumer is determined to continue to be eligible for the DSAMH LTC system, the EEU will confirm this with the Primary Service Provider. If the consumer is to be disenrolled, the process in Section VIII. is followed.

VII. REQUESTS FOR RE-DETERMINATION

In situations where the Primary Service Provider initiates the re-determination process, it will notify the EEU of consumers/clients enrolled in the DSAMH LTC system who are judged to no longer need long term behavioral health services

due to improvement in their behavioral health status and their success in recovery. The primary service provider must submit a **Request for Re-Determination** and notify the consumer of this request; the **Request for Re-Determination** will include a certification that the consumer has been notified and wants to return to the basic benefit. The **Request for Re-Determination** will also describe why the client no longer needs LTC, as well as a summary of treatment plans (including recommendations for current treatment) and a description of the client's ongoing self-care and relapse prevention plan. When the EEU receives this request, it will notify the enrollee of their right to dispute this recommendation and provide them with the procedures for doing so. If the consumer disputes the provider's recommendation, the EEU will take this into consideration during its review. When the consumer is requesting a re-determination, the DSAMH Office of Consumer Affairs will assist the consumer in submitting the **Consumer Request for Re-Determination.**

The EEU will review the **Request for Re-Determination** and make a determination within five (5) working days as to whether the consumer will be disenrolled from the LTC System. The EEU will notify the Primary Service Provider and the consumer of the results of this determination within two (2) working days of the review's completion. When the provider has requested disenrollment and the EEU determines that the consumer should continue to be enrolled, this decision is made with the concurrence of the EEU physician. The EEU will send the **Eligibility Determination Summary** to the Primary Service Provider.

VIII. RE-DETERMINATION DENIALS AND APPEALS

If the EEU has determined that an individual is no longer in need of long term behavioral healthcare, the disenrollment decision will be made by an EEU physician. The EEU will issue a disenrollment letter which will include an explanation of the bases for disenrollment and will include the **Eligibility Determination Summary** with this letter. The primary service provider or the enrollee has the right to resubmit the disenrollment request within ten (10) working days or to appeal the decision. If the provider or the consumer chooses to appeal the decision, a written appeal must be filed with the DSAMH Deputy Director or designee within five (5) working days of the notification of determination. DSAMH will issue a response to appeals within five (5) working days; a disenrollment decision which is upheld is subject to a second level appeal.

For Medicaid enrolled consumers, the second level appeal will be heard by the Division of Social Services.

IX. DISENROLLMENT

The EEU will assume primary responsibilities for administering the disenrollment process. Responsibilities will include: final approval of a change in service status; final authorization of disenrollment from the DSAMH LTC system; and the processing of disenrollment information to the Division of Social Services/Medicaid Office for Medicaid beneficiaries.

A program participant may be disenrolled from the DSAMH LTC system under the following circumstances:

- Improvement in behavioral health status, as indicated by a combination of the following:

  - a change in diagnosis and/or functioning no longer indicating a need for long
    term intensive service provision;
    evidence that the enrollee has not needed/utilized higher levels of care
  - stable medication history;
  - stable psychosocial factors as demonstrated by an assessment of functioning and quality of life scales; or

- Placement in a correctional facility (detainee or un-sentenced vs. sentenced); or

- Inpatient treatment in a nursing facility beyond a continuous sixty day period prior to the request for disenrollment; or

- Relocation to another state; or

- Death of participant.

In order to effect a disenrollment, the EEU will request that the primary service provider submit a DSAMH LTC Client Discharge Summary. The DSAMH LTC Discharge Summary will include: a summary of the enrollee's treatment plans; medications; and other pertinent information required to promote the most successful transfer for the client. The Discharge Summary will provide recommendations on treatment and support required to continue the consumer's recover, including the methods to be used for ongoing self-care and relapse prevention. As part of this process, the EEU will confirm the consumer's Medicaid eligibility before referring a consumer back to the DSHP MCO or a treatment provider for the basic benefit and will change the SPI flag in the MMIS for Medicaid beneficiaries.

When management of the consumer's behavioral health care is to be returned to a Medicaid DSHP MCO, the EEU will ensure that the Primary Service Provider coordinates with the consumer's/client's MCO to effect a clinically appropriate transition of care.