CRAWFORD COUNTY HUMAN SERVICES
632 Arch Street, Suite B101
Meadville, PA 16335
(814) 724-8380
Toll Free: (877) 334-8793
Fax: (814) 337-8080

Mental Health, Early Intervention, Mental Retardation, Waiver and Children & Youth Programs

RE: Fiscal Year 2006-2007 Provider Budget Submissions for Mental Health, Early Intervention, Mental Retardation, Waiver and Children and Youth Programs

Dear Provider,

Enclosed you will find a file containing Crawford County's fiscal year 2006-2007 budget request. This file contains both Excel and Word documents. Please be sure to open all pages. There is one Word document containing seven pages, and two Excel files, one containing seven pages, which all need to be completed. All spreadsheets have been tested for formula and macro accuracy. Please revalidate the formulas in the event a flaw is still resident.

Please note, you will need to make a duplicate copy/copies of the budget forms to ensure there are separate submissions for all MH/EI, MR, Waiver programs and/or CYS programs within your agency (example – if you have CYS Homemaker program, Foster Care program and a Shelter program, you need to submit individual budget forms for each program). Also, a Consolidated Agency Budget form, which shows all program totals on one consolidated form needs to be submitted. Individual budget forms can be found in the attached file labeled "provider budgets", and then clicking on the sheet tabs at the bottom to get to each of the seven pages. Please review the checklist of proposal forms and submission requirements, as new items have been added for this budget year.

I hope you will find these spreadsheets user friendly. Please note that the Utilization Summary Form (Tab Utiliz) **is to be completed by all providers**.

There is no anticipated increase in State funding, please prepare your budgets with a zero percent (0%) increase. Should this change, we will adjust the contracts accordingly.

Completed Budget packages are to be returned to our office no later than three working days before your scheduled budget meeting with Crawford County Human Services. Please return one completed budget submission via hard copy to our office.

Our office is committed to assisting you with this process. The fiscal staff is available should you have any questions. We look forward too working with you. To schedule a budget meeting, please call 814-336-4352 and speak to Mary James. If you have questions on the spreadsheets, the point of contact is Ralph Lee or Sherry Stanton at (814) 373-2634 / 2604.

When attending your scheduled budget meeting, please bring your calendar or organizer with you to the Budget negotiations in case a follow up meeting needs to be scheduled.

CHECKLIST OF PROP0SAL FORMS AND SUBMISSION REQUIREMENTS

(FY 2006-2007)

A completed Proposal Information Packet is to be submitted to Crawford County Human Services Office to the attention of Ralph Lee at least three working days before your scheduled budget negotiation meeting. Submissions include the following completed forms and documents:

- ❑ Agency Cover Page
- ❑ Service Rate Cover Page(s)
- ❑ Consolidated Agency Budget*
- ❑ Statement of Functional Cost*
- ❑ Statement of Revenue and Calculation of Cost Charged to County*
- ❑ Personnel Report*
- ❑ Calculation of Allowable Per Diem*
- ❑ Breakout of Fringe Benefits
- ❑ Program Description for Each Program
- ❑ DPW License/Certificates of Compliance
- ❑ Narrative Explanation of Supplemental Information Regarding Agency Costs
- ❑ Insurance Certificate(s) listing Crawford County Human Services, Crawford County Courthouse, and Crawford County Commissioners as additionally insured.
- ❑ List of Board of Directors
- ❑ ## Attachment C Rate Sheet for **CYS Providers Only**. Please provide a rate sheet

(Attachment C) on your letterhead. List each program and rate - please note definition of unit (ex: hourly, perdiem) and also the IV-E rate if applicable. Also, **please list the IV-E rate for all foster care, shelter, group home, institutional, independent living, residential programs, and MA billable**.

❑ ## Mental Retardation and Waiver Providers only: Please utilize the office of Mental Retardation's (OMR) new service definitions effective July 1, 2006. See attached letter dated March 2, 2006 from Crawford County's MR Program Specialists.

❑ ## Cost Allocation Plan for Mental Health, Mental Retardation, Waiver and Early Intervention providers.

If your agency participates in fund raising activities, these costs should be recognized and described in the agency cost allocation plan. Please list in detail how much money will be expensed to raise the funds. If a related party is involved in the fundraising, please explain how costs will be funded and how profits will be handled.

❑ Agency Referral Form (**CYS Providers Only**).

❑ MR/WV Consumer List for each program (Mental Retardation and Waiver Providers only). Please include a list of names showing each consumer served under each program. For each consumer, please list hours serviced, especially for the Home and Community Program and hours authorized.

❑ ## Depreciation narrative: On the Budget forms - page 2-, under General Expenses, Item J Depreciation, if there is an amount entered for FY 05-06 or 06-07, a narrative description is needed. Please list item, amount and if there is a loan for the equipment.

*Use enclosed preformatted file/disc, or forms.

Indicates new requirement

AGENCY COVER PAGE

(FY 2006-2007)

1. Full legal name and address of agency

   Agency name: _____

   Address: _____

   City/State/Zip:_____

   Telephone: (_____)_____

   Fax: (_____)_____

   Email for Agency Director: _____

   Email for Fiscal Contact: __ _____

2. Legal status: _____ non-profit _____ profit

3. Agency Executive Director/CEO

   _____
   (Name) (Title)

4. Name and title of agency fiscal contact person:

   _____
   (Name) (Title)

PROGRAM DESCRIPTION OUTLINE
FOR SERVICES

(FY 2006-2007)

1. The document must be titled: **Program Description**
   Fiscal Year 2006-2007

2. Identify your Agency Name, Program Name for the service and facility locations. Identify your agency telephone number, your programs telephone number if applicable, and your facilities telephone number(s) if applicable. Identify your agency business hours and your program business hours and days of the week. Also, please include your e-mail address and contact names, with phone and extension number for each program.

3. Describe the service. A Program Description is to be submitted for each Service per diem. Include the target population, work to be performed, goals, and outcomes. Limit your description to no more than one (1)-typed page.

4. Identify the process for referral, general inquiry, and emergency contact.

5. What are the staff hours? Please define how many staff and hours worked. Also, please note if overnight staff are awake.

6. Briefly describe the **minimum** direct staff to consumer ratio. Count only the individual responsible for the care of consumers. Do not count clerical or administrative staff.

7. Briefly describe the **average** direct service staff to consumer ratio. Count only the individuals responsible for the care of the consumers. Do not count clerical or administrative staff.

8. List by position title the minimum qualifications for direct service staff and supervisory staff of this program.

9. Briefly describe your training plan for direct service staff.

10. What is the average length of stay for consumers in this program?

11. If applicable, briefly describe the **therapeutic services** provided to consumers and specify the minimum frequency of sessions.

12. If applicable, briefly describe the minimum and typical qualifications of the person(s) providing treatment of any **therapeutic services,** and indicate what services are directly provided and what services another party provides.

13. Do you offer any **specialized services** for consumers? If so, briefly describe the services

provided, unless you have specified those services above.

14. Briefly describe the services you provide to consumers in order to equip them with **independent living skills**.

15. Briefly describe any features or special services that you provide, which have not been described above, that make your program unique.

16. Please include copies of any certificates or licenses that may be applicable to any of the above services.

17. Please include an organizational chart..

18. Briefly describe your internal mechanism or plan for quality improvement of services, and the agency as a whole.

19. Please include a description of your agency's emergency/disaster plan and indicate how staff and consumers are made aware of the plan.

20. Briefly describe how your agency incorporates CSP principals into the everyday services provided by your agency. **MH Providers only.**

21. Please indicate a statement of willingness to comply with requested service provision as authorized. **All providers.**

22. Please describe how transportation costs are handled. **CYS Providers only.**

23. Please include a copy of your monthly report outlines and also a copy of the entrance/exit consumer needs assessment tool. (CYS Providers only).

24. Please include your outcome measures required from all CYS providers.

DATE: Thursday, March 2, 2006

TO: All Agencies Contracted to Provide MR Services for Crawford County

FROM: Crawford County Human Services
Jill Gillette/Valerie King/Tamela Hall
MR Program Specialists

RE: FY 06-07 Budgets and Rate Setting Procedures
and New Service Definitions

2006-2007 BUDGETS:

Crawford County is requesting all agencies contracting to provide MR services in Crawford County utilize our current budget packets for developing rates for fiscal year 2006/2007. The forms will be available on the County portal and will also be available at the fiscal Provider Meeting on Thursday, March 9, 2006. We will also provide a calendar for providers to sign up for budget negotiation meetings.

In addition, after using Crawford County's budget forms to develop your agency's rates, please practice using OMR's rate setting packet (available but still unfinalized on DPW's ListServe website; will also be available on Crawford County Human Services' portal.) Fiscal year 2006-2007 and 2007-2008 are practice years for using OMR's rate setting packet. Let's use our practice years wisely to work out as many problems as possible and become familiar with OMR's new forms. Please bring your agency's OMR Rate Setting forms to budget negotiations in addition to the completed County Budget forms. Please be prepared to discuss problems, questions, and/or concerns regarding how the OMR forms worked for you.

2006-2007 NEW SERVICE DEFINITIONS:

When developing your rates using Crawford County's budget forms, please utilize OMR's new Service Definitions that you received in an OMR Bulletin earlier this February from Mary James. Please feel free to contact her at (814) 373-2600 if you need additional copies of the new Service Definitions.

Service Name	July 1, 2006, Approved Units	Prior to July 1, 2006, Units
Home and Community Habilitation (unlicensed agencies)	15 minute units	Hourly units
Community Habilitation (licensed agencies)	½ day units	Hourly units
Pre-Vocational Services	½ day units	Hourly units
Transitional Work Services	15 minute units	Hourly units
Family Living Homes	½ month units	Daily units
Community Homes	½ month units	Daily units
Respite	daily units and 15 minute units	Daily and hourly units
Therapies (PT, OT, Speech and Language, individual, group)	15 minute units *(waiver can pay for therapy only when the therapy for the individual is MA eligible* and *the individual has reached the MA cap for the service* and *a MA denial is present. Waiver cannot pay for a therapy if the individual is not eligible for the therapy; if the therapy is MA billable; if the therapy is MA billable and has not reached the MA cap for the service.)*	15 minutes, ½ hour, and hourly units

REMEMBER:

- Provide Crawford County Human Services with your agency's completed County budget forms *at least three days prior to* the scheduled negotiation date

- Include your agency's 2% COLA and Direct Service Worker Initiative (DSWI) funding received this fiscal year in your 2006/2007 unit rates
- Bring your agency's completed OMR Rate Setting Forms to negotiations

SERVICE RATE COVER PAGE

(FY 2006-2007)

Agency Name: _____

Type of Service: _____

Per Diem

2005-2006 Rate	2006-2007 Computed Rate	2006-2007 Requested Rate	Requested $Inc./Dec.	Requested %Inc./Dec.

Hourly Rate

2005-2006 Rate	2006-2007 Computed Rate	Requested Rate	Requested %Inc./Dec.

Total 2006-2007 Budget for Hourly Rate: _____

Program Funded

2005-2006 Amount		2006-2007 Requested Amount	Requested $Inc./Dec.	

Requested
%Inc./Dec.

CONSOLIDATED AGENCY BUDGET INSTRUCTIONS

(FY 2006-2007)

A single Consolidated Agency Budget form is to be submitted for each agency.

This spreadsheet presents an overview of the entire, or *consolidated*, agency budget, including both County funded services and programs provided through other funding. This presentation is intended to show how the County funding for the Services that are the subject of this Proposal Information Packet fits into the total agency budget. *Columns entitled "Other" reflect other major service divisions or programs.*

Note: Each Service purchased by County must have its own column.

If a large number of columns on this sheet make the print too small:

- First, eliminate unnecessary white space due to excessive column width, wide margins, etc.
- If the numbers are still too small, print the sheet on two pages.