COORDINATED OPIOD RECOVERY PROGRAM SERVICES AGREEMENT

THIS AGREEMENT, dated this _____day of _____ entered into by and between:

BROWARD BEHAVIORAL HEALTH COALITION, INC., a non-profit corporation organized and operating in accordance with the laws of the State of Florida, with a business address of 3521 West Broward Boulevard, Suite 206, Lauderhill, Florida 33312, hereinafter referred to as "BBHC;"

and

CITY OF FORT LAUDERDALE, a municipal corporation of the State of Florida, with a business address located at 101 NE 3rd Avenue, Suite 2199, Fort Lauderdale, Florida 33301, hereinafter referred to as "CITY."

WHEREAS, BBHC contracts with the Florida Department of Children and Families ("DCF") pursuant to §394.9082, Florida Statutes; and

WHEREAS, BBHC desires to contract with CITY, as required and funded by DCF, to provide services specified in this Services Agreement herein below; and

WHEREAS, CITY represents that it has the professional knowledge, skills, abilities, experiences, and expertise to provide the services required pursuant to this Agreement and that they are ready, willing and able to perform such professional services;

NOW THEREFORE, in consideration of the mutual promises, covenants, and obligations set forth herein, and other good and valuable consideration, the receipt of which is hereby acknowledged, the parties mutually agree as follows:

ARTICLE I. PREAMBLE

1.1 The foregoing "whereas" clauses are true and correct and hereby incorporated into this Agreement.

ARTICLE II. SERVICES AND RESPONSIBILITIES

2.1 CITY hereby agrees to perform the professional services described in **Exhibit "A"** attached hereto and incorporated herein. The services will be performed in accordance with the requirements of this Agreement. In case of a conflict or a perceived conflict between this Agreement and any other document or understanding, the terms and conditions of this Agreement shall control. Except as provided for in this Agreement, in the event there is a conflict between the Scope of Services as set forth in **Exhibit "A"** and the Agreement (including any amendments), the Scope of Services shall prevail.

2.2 CITY shall furnish all services, labor, equipment, and materials necessary and as may be required in the performance of this Agreement and all work performed pursuant to this Agreement shall be done in a professional manner.

2.3 CITY hereby represents to BBHC, with full knowledge that BBHC is relying upon these representations when entering into this Agreement that CITY has the professional expertise, experience, and manpower, as well as holds the necessary permits, certifications, and licenses required to perform the services to be provided by CITY pursuant to the terms of this Agreement.

2.4 BBHC agrees to assist and cooperate with CITY in the performance of this Agreement by providing CITY with all necessary information required in the performance of CITY's services hereunder.

ARTICLE III. COMPENSATION

3.1 BBHC agrees to compensate CITY for all services performed and required by this Agreement pursuant to the Scope of Services set forth in **Exhibit "A"** a total amount not to exceed **Five Hundred Thousand Dollars and no cents ($500,000.00).** Payments will be made upon timely submission of CITY's detailed invoice for service. No payments will be made to the CITY until BBHC receives a written and accurate invoice from the CITY for services rendered. Invoices are due to BBHC from CITY on or before the 5th day of the month beginning the first month following execution of this Agreement unless otherwise authorized by BBHC in writing.

3.2 Any costs that are not covered as part of the monthly fee must be approved by BBHC prior to being invoiced. BBHC will not pay for any unapproved or unauthorized expenses.

3.3 BBHC agrees to make payment to CITY pursuant to the applicable rate for Services as provided in **Exhibit "B"** that CITY actually renders as invoiced and documented within thirty (30) calendar days of receiving an accurate invoice.

3.4 CITY must submit to BBHC documentation evidencing the provision of Services supporting the invoices submitted for payment. All invoices shall be submitted in the form prescribed by BBHC. Invoices or documentation returned to CITY for corrections will be cause for delay in receipt of payment. Late submission will result in delay in CITY's receipt of payment.

3.5 Payment will be made by BBHC to CITY at the address provided in Article XXII herein below, unless CITY advises BBHC in writing of another location.

3.6 Upon execution of this Agreement, and prior to receiving any payment hereunder, CITY must submit all required tax forms to BBHC. CITY's invoices must include CITY's taxpayer identification number (Employer Identification number) in accordance with requirements of the Internal Revenue Service. Invoices shall contain receipts or documentation that is satisfactory to BBHC. The CITY must submit a report with the invoice which includes a description of the activities completed during the previous month.

3.7 CITY warrants and covenants to BBHC that the invoices it submits to BBHC hereunder shall be fair and reasonable.

3.8 CITY agrees to pay all applicable income, sales, consumer, use, and other similar taxes as may be required by law.

3.9 BBHC will pay CITY as required by the Florida Prompt Payment Act, §§218.70-218.80, Florida Statutes, and the "Broward County Prompt Payment Ordinance," Section 1-51.6, Broward County Code of Ordinances. Further, BBHC may deduct any monies due to CITY from any outstanding invoice due pursuant to this Agreement, if BBHC identifies money due from CITY through monitoring, audit, or other contractual review following notice.

3.10 CITY represents to BBHC that no other reimbursement or payment is available or will be received by CITY for any Services invoiced to BBHC, and BBHC hereby acknowledges that has relied upon such representation.

ARTICLE IV. TERM AND TERMINATION

4.1 This Agreement shall commence on **June 1, 2024**, and terminate on **June 30, 2026.** BBHC reserves the right to alter the starting and ending dates according to the needs of BBHC. Such modifications shall be communicated to CITY in writing.

4.2 Renewal. CITY understands and acknowledges that, although its performance under this Agreement will be considered by BBHC in evaluating future or additional funding requests, funding under this Agreement relates exclusively to the Initial Term and that BBHC, by entering into this Agreement with CITY, assumes no obligation whatsoever with respect to further or future funding to CITY.

This Agreement may be terminated by either party with or without cause, immediately upon fourteen (14) days written notice. Upon termination by BBHC, CITY shall cease all work performed hereunder and BBHC shall pay CITY any earned and unpaid portion of the compensation due CITY pursuant to Article III, immediately discontinue all services affected, and deliver to BBHC all data, reports, summaries, and such other information and materials as may have been prepared for and/or accumulated by the CITY in performing this Agreement, whether completed or in progress. CITY will be compensated for work completed up until the date of termination.

4.3 CITY shall maintain the records, books, documents, and papers associated with this Agreement in accordance with Chapter 119, Florida Statutes. Upon termination, all finished or unfinished documents, data, studies, reports, handouts and materials produced for the services rendered hereunder, upon request and at no additional cost to BBHC, CITY will facilitate the timely duplication and delivery of any records or documents produced during the term of this Agreement and during the required retention period thereafter, to BBHC.

ARTICLE V. CHANGES TO SCOPE OF WORK OR ADDITIONAL WORK

5.1 BBHC or CITY may request changes that would increase, decrease, or otherwise modify the Scope of Services, as set forth in **Exhibit "A**,**"** to be provided under this Agreement. Such changes or additional services must be contained in a written amendment, executed by the parties hereto, with the same formality and with equal dignity herewith prior to any deviation from the Term or Scope of this Agreement, including the initiation of any additional or extra work. In no event will CITY be compensated for any work which has not been described in a separate written agreement executed by the Parties hereto.

ARTICLE VI. CLASSIFIED/RESTRICTED PROPRIETARY DATA.

6.1 BBHC agrees to apprise the CITY as to any information or items made available hereunder to the CITY, which are confidential, classified, restricted, or proprietary data. The CITY agrees that any such confidential classified, restricted, or proprietary data will not be disclosed to other parties without express approval in writing from BBHC, unless required by Florida law. The CITY further agrees that any such material furnished to them by BBHC will be reproduced and delivered to BBHC at its request or upon termination of this Agreement, but that such records shall retain its classified or proprietary status in accordance with the restrictions under Florida's Public Records laws.

ARTICLE VII. INDEMNIFICATION

7.1 CITY is a governmental entity and is fully responsible for the acts and omissions of its agents, officers, or employees, subject to any applicable limitations of §768.28, Florida Statutes. Nothing herein is intended to serve as a waiver of sovereign immunity by CITY or BBHC, nor shall anything included herein be construed as consent by either party or DCF to be sued by third parties in any matter arising out of this Agreement. Pursuant to the provisions of §768.28, Florida Statutes, CITY, BBHC, and DCF shall be responsible for the negligent or wrongful acts or omissions of its respective employees pursuant to §768.28, Florida Statutes. Neither CITY, BBHC, nor DCF intend to directly or substantially benefit a third party by this Agreement. Therefore, the Parties acknowledge that there are no third-party beneficiaries to this Agreement and that no third party shall be entitled to assert a right or claim against either of them based upon this Agreement.

ARTICLE VIII. INSURANCE

8.1 For the duration of the Agreement, CITY must, at its sole expense, maintain the minimum insurance coverages stated in **Exhibit "C**,**"** attached hereto and incorporated herein, and in accordance with the terms and conditions of this Article. CITY must maintain insurance coverage against claims relating to any act or omission by CITY, its agents, representatives, employees, or subcontractors in connection with this Agreement. To the extent that the CITY is self-insured pursuant to Ch. 768, Florida Statutes, for any or all portions of its liability arising out

of or associated with this Agreement, CITY shall provide BBHC with written verification of liability protection that meets or exceeds any requirements of Florida law.

8.2 CITY shall not commence performance hereunder until it has obtained all insurance or provided evidence of self-insurance as required under this section and such insurance has been approved by BBHC. Nor shall the CITY allow any subcontractor to commence work on his subcontract until all similar such insurance required of the subcontractor has been obtained and similarly approved. CITY shall be liable to BBHC for any lapses in service resulting from a gap in insurance coverage.

8.3 If CITY holds any excess liability coverage, CITY must ensure that Broward Behavioral Health Coalition, Inc. and the Florida Department of Children and Families are listed as additional insureds and certificate holders under such excess liability policies and provide evidence of same to BBHC in accordance with **Exhibit "C"** attached hereto and incorporated herein, and this Article.

8.4 CITY must ensure that all insurance coverages required by this article remain in full force and effect for the duration of this Agreement and until all performance required by CONTRACTOR has been completed, as determined by BBHC. CITY or its subcontractor must provide notice to BBHC of any cancellation or modification of any required policy at least twenty-five (25) days prior to the effective date of cancellation or modification, and at least five (5) days prior to the effective date of any cancellation due to nonpayment and must concurrently provide BBHC with a copy of its updated Certificates of Insurance evidencing continuation of the required coverages. CITY must ensure that there is no lapse of coverage at any time during the time period for which coverage is required by this article.

8.5 If at any time CITY is not self-insured, CITY must ensure that all required insurance policies are issued by insurers:

(1) assigned an A. M. Best rating of at least A- with a Financial Size Category of at least Class VII;
(2) authorized to transact insurance in the State of Florida; or
(3) a qualified eligible surplus lines insurer pursuant to §626.917 or 626.918, Florida Statutes, with approval by BBHC.

8.6 If CITY maintains broader coverage or higher limits than the minimum insurance requirements stated in **Exhibit "C**,**"** CITY will be entitled to any such broader coverage and higher limits maintained by CITY. All required insurance coverages under this article must provide primary coverage and must not require contribution from any BBHC insurance, self-insurance or otherwise, which must be in excess of and must not contribute to the insurance required and provided by CITY.

8.7 CITY must declare in writing any self-insured retentions or deductibles over the limit(s) prescribed in **Exhibit "C"** and submit to BBHC for approval. CITY will be solely responsible

for and must pay any deductible or self-insured retention applicable to any claim against BBHC. BBHC may require CITY to purchase coverage with a lower retention or provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention. CITY agrees that any deductible or self-insured retention may be satisfied by either the named insured or BBHC, if so, elected by BBHC, and CITY agrees to obtain same in endorsements to the required policies.

8.8 Any required workers' compensation or employer's liability insurance must include any applicable federal or state employer's liability laws including, but not limited to, the Federal Employer's Liability Act, the Jones Act, and the Longshoreman and Harbor Workers' Compensation Act. Any required professional liability insurance must include coverage for all claims that are reported within at least three (3) years following the expiration or termination of this Agreement unless a longer period is indicated in **Exhibit "C."**

ARTICLE IX. EXAMINATION OF RECORDS; PUBLIC RECORDS; AND AUDIT RIGHTS

9.1 BBHC shall have reasonable access and the right to examine any directly pertinent books, documents, papers, and records of CITY involving transactions related to this Agreement until the expiration of three (3) years after final payment hereunder, during normal business hours.

9.2 To the extent either party is acting on behalf of the other party, as stated in §119.0701, Florida Statutes, that party must:

a. Keep and maintain public records that ordinarily and necessarily would be required in order to perform the services under this Agreement;

b. Upon request from the other party, provide the public with access to such public records on the same terms and conditions it would provide the records and at a cost that does not exceed that provided in Chapter 119, Florida Statutes, or as otherwise provided by law;

c. Ensure that public records that are exempt or that are confidential and exempt from public record requirements are not disclosed except as authorized by law for the duration of this Agreement and following completion or termination of this Agreement; and

d. Upon completion or termination of this Agreement, provide access to the other party, at no cost, all public records in their possession of or keep and maintain public records required to perform the Services.

Pursuant to Florida's Public Records laws both parties shall meet all applicable requirements for retaining public records. All records stored electronically must be provided to BBHC upon request in a format that is compatible with the information technology systems of BBHC.

Both parties shall have the right to immediately terminate this Agreement for the refusal by the other party to comply with these requirements or Chapter 119, Florida Statutes.

IF EITHER PARTY HAS QUESTIONS REGARDING THE APPLICATION OF CHAPTER 119, FLORIDA STATUTES, TO PROVIDE PUBLIC RECORDS RELATING TO THIS AGREEMENT, THEY SHALL CONTACT THE OTHER PARTY'S CUSTODIAN OF PUBLIC RECORDS AT:

BROWARD BEHAVIORAL HEALTH COALITION, INC.
3521 WEST BROWARD BOULEVARD, SUITE 206
LAUDERHILL, FL 33312
SILVIA.QUINTANA@BROWARDBEHAVIORALHC.ORG
PHONE NUMBER: (954) 622-8121

CITY OF FORT LAUDERDALE
CUSTODIAN OF PUBLIC RECORDS
ONE EAST BROWARD BOULEVARD, SUITE 444
FORT LAUDERDALE, FL 33301
PRRCONTRACT@FORTLAUDERDALE.GOV
(954) 828-5002

9.3 BBHC reserves the right to audit the CITY's books, records, and accounts pertaining to this Agreement at any time, during normal business hours during the term of the Agreement during the performance and term of the Agreement, and for a period of three (3) years after termination or expiration of this Agreement, or until resolution of any audit findings, whichever is longer. CITY also agrees to allow any BBHC representative (including any outside representative engaged by BBHC) audit or inspect financial records, supporting documents, statistical records, and any other documents pertinent to this Agreement. If an auditor determines that the CITY was paid for Services not performed or paid in excess of materials or services provided, the CITY shall reimburse the BBHC for such overpayment. CITY hereby grants BBHC the right to conduct such audit or review at CITY's place of business, if deemed appropriate by BBHC, with seventy-two (72) hours' advance notice.

CITY must keep such books, records, and accounts as may be necessary in order to record complete and correct entries related to this Agreement and performance under this Agreement. All such books, records, and accounts shall be kept in written form, or in a form capable of

conversion into written form within a reasonable time, and upon request to do so, CITY must make the same available in written form at no cost to BBHC.

Any incomplete or incorrect entry in such books, records, and accounts shall be a basis for CITY's disallowance and recovery of any payment upon such entry. If an audit or inspection in accordance with this section discloses overpricing or overcharges to BBHC of any nature by CITY in excess of five percent (5%) of the total contract billings reviewed by BBHC, the reasonable actual cost of the audit shall be reimbursed to BBHC by CITY in addition to making adjustments for the overcharges. Any adjustments or payments due as a result of such audit or inspection shall be made within thirty (30) daysafter presentation of such findings to CITY.

ARTICLE X. CONFLICT OF INTEREST

10.1 CITY covenants that it presently has no interest direct or indirect which would conflict in any manner or degree with the performance of its services hereunder and that it shall not employ any person having such conflicting interests in the performance of the Agreement. ***CITY further covenants that CITY, and any person employed by CITY in the performance of this Agreement, shall comply with BBHC's Conflict of Interest Policy attached as Exhibit "D" and incorporated herein.***

ARTICLE XI. PUBLICITY; RESTRICTION ON THE USE OF NAME, LOGO

11.1 It is also agreed that no advertising publicity matter having or containing any reference to BBHC or in which the name is mentioned, shall be used nor shall any other use of BBHC's employees' names, logos, or trademarks be made by the CITY or anyone on the CITY's behalf unless and until the same shall have first been submitted to and received the written approval of an authorized representative of BBHC.

ARTICLE XII. CERTIFICATIONS AND LICENSES

12.1 CITY represents and warrants that all employees have and maintain their respective licenses and certification and any of its agents, employees, or subcontractors, or anyone directly or indirectly employed by either, has or will obtain and maintain in force and effect throughout the term of this Agreement, any and all certificates, licenses and permits necessary for CITY to fulfill its obligations herein or required by any applicable federal, state or local law, regulation or ordinance or any professional organization.

ARTICLE XIII. WAIVER OF DEFAULT

13.1 Any failure by BBHC at any time, or from time to time, to enforce or require the strict keeping and performance by CITY any of the terms or conditions of this Agreement shall not constitute a waiver by BBHC of a breach of any such terms or conditions and shall not affect or impair such terms or conditions in any way, or right of BBHC at any time to avail itself of such remedies as it may have, for any such breach or breaches of such terms or conditions.

ARTICLE XIV. INDEPENDENT CONTRACTOR

14.1 This Agreement does not create an employee/employer relationship between the Parties. It is the intent of the Parties that the CITY is an independent contractor under this Agreement and not BBHC's employee for any purposes, including but not limited to, the application of the Fair Labor Standards Act minimum wage and overtime payments, Federal Insurance Contribution Act, the Social Security Act, the Federal Unemployment Tax Act, the provisions of the Internal Revenue Code, the State Worker's Compensation Act, and the State Unemployment Insurance law. Nothing in this Agreement constitutes or creates a partnership, joint venture, or any other relationship between the Parties. CITY shall retain sole and absolute discretion in the judgment of the manner and means of carrying out CITY's activities and responsibilities hereunder provided, further that administrative procedures applicable to services rendered under this Agreement shall be those of CITY, which policies of CITY shall not conflict with those of BBHC, the State, or United States policies, rules or regulations relating to the use of CITY's funds provided for herein. CITY agrees that it is a separate and independent enterprise from BBHC, that it had full opportunity to find other business, that it has made its own investment in its business, and that it will utilize a high level of skill necessary to perform the work. This Agreement shall not be construed as creating any joint employment relationship between CITY and BBHC and BBHC will not be liable for any obligation incurred by CITY, including but not limited to unpaid or minimum wages and/or overtime premiums.

14.2 CITY shall pay all contributions, taxes, and premiums payable under Federal, State, and Local Laws upon the payroll of employees engaged in the performance of work under this Agreement, and all sales, use, excise, transportation, privilege, occupational, and other taxes applicable to materials and supplies furnished or work performed hereunder.

ARTICLE XV. GOVERNING LAW; JURISDICTION; VENUE

15.1 Any provisions required to be included in a contract of this type by any applicable and valid Federal, State or Local Law, Ordinance, Rule, or Regulation shall be deemed to be incorporated herein. This Agreement shall be governed by Florida Law and disputes arising hereunder shall be subject to the jurisdiction and venue of the State or Federal Courts residing in Broward County, Florida.

ARTICLE XVI. AFFIRMATIVE ACTION

16.1 No party to this Agreement may discriminate on the basis of race, color, sex, religion, national origin, disability, age, marital status, political affiliation, sexual orientation, pregnancy, or gender identity and expression in the performance of this Agreement. CITY agrees to adhere to the principles and requirements set forth in all State, Federal and Local Laws including those pertaining to non-discrimination, such as the Equal Opportunity clause contained in section 202 of Executive Order 11246. CITY specifically agrees to comply with the following

EEO clauses that are hereby incorporated by reference: 41 CFR 60-1.4; 41 CRF 60-250.4 and 41 CRF 60-741.4.

16.2 CITY further agrees by entering into this Agreement to maintain employment policies and practices that affirmatively promote equality of opportunity for minority-group persons and women; to take affirmative steps to hire and promote women and minority-group persons at all job levels and in all aspects of employment, with outside recruiting services and the minority community at large; and provide non-segregated facilities for all employees.

16.3 CITY shall maintain a Drug-Free workplace as pursuant to § 112.0455, Florida Statutes.

ARTICLE XVI. MISCELLANEOUS PROVISIONS

17.1 **Conflict of Terms**. In the event of any conflict between this Agreement, all attachments and documents incorporated herein and other documents that may be part of this Agreement**,** the language of this Agreement shall govern.

17.2 **Severability**. Any provision in this Agreement that is prohibited or unenforceable in any jurisdiction shall, as to such jurisdiction, be ineffective to the extent of such prohibition or unenforceability without invalidating or affecting the validity of the remaining provisions of this Agreement.

17.3 **Exhibits.** Each exhibit referred to in this Agreement forms an essential part of this Agreement. Even if not physically attached, the exhibits should be treated as an essential element and therefore a part of this Agreement and are hereby incorporated herein by this reference.

17.4 CITY shall abide by all of the applicable DCF contracts, including the DCF CORe Grant Guidance, and SAMHSA grant principles, standards, and requirements, and CITY acknowledges that such covenants and representations are part of, and are incorporated by reference into this Agreement. These documents are attached as exhibits as indicated and incorporated herein by reference. For further reference and ease of access, they may also be found at the following links:

17.4.1 BBHC Provider Handbook **(Exhibit "E")** may be found:

https://bbhcflorida.org/wp-content/uploads/2024/02/BBHC-Handbook-for-FY23-24-Version-7.02_FINAL_2.pdf

17.4.2. BBHC DCF Contract **(Exhibit "F")** may be found:

https://www.myflfamilies.com/services/samh/providers/managing-entities/FY23-24

17.4.3. CORe Grant Guidance **(Exhibit "G")** may be found: https://www.myflfamilies.com/sites/default/files/2023-10/Guidance%2041%20-%20CORE%20.pdf

17.5 **Merger.** This Agreement constitutes the entire Agreement between the parties. All negotiations and oral understandings between the Parties are merged herein.

17.6 **Legal Representation.** Each party to this Agreement expressly acknowledges that this Agreement results from the negotiations between the parties. Each party contributed to the drafting of this Agreement and had the opportunity to be represented by legal **counsel**. Accordingly, the rule that a contract shall be interpreted strictly against the party preparing same shall not apply herein due to the joint contributions of both parties.

17.7 **Headings.** Headings herein are for the convenience of reference only and shall not be considered in any interpretation of this Agreement.

17.8 **Counterparts.** This Agreement may be signed in one or more counterparts, each of which when executed shall be deemed an original and together shall constitute one and the same instrument.

17.9 **Authority.** The persons signing this Agreement below represent and warrant that they have full authority to execute this Agreement on behalf of the party for whom (s)he is signing and to bind such party with respect to all provisions contained in this Agreement.

17.10 **Compliance with Laws**.

17.10.1 CITY and the Services it provides must comply with all applicable federal, state, and local laws, codes, ordinances, rules, and regulations, including, without limitation, American with Disabilities Act, 42 U.S.C. § 12101, Section 504 of the Rehabilitation Act of 1973, and any related federal, state, or local laws, rules, and regulations.

17.10.2 CITY shall comply with the provisions of the Byrd Amendment (31 U.S.C. 1352) prohibiting the use of appropriated funds to pay any person for influencing or attempting to influence the executive or legislative branch with respect to certain specified actions.

17.11 If this Agreement involves over $100,000 of Federal Funds, CITY shall comply with all applicable standards, orders or regulations issued under section 306 of the Clean Air Act, as amended the Clean Air Act, as amended (42 U.S.C. §7401 et seq.), Section 508 of the Federal Water Pollution Control Act, as amended (33 U.S. C. §1251 et seq.), Executive Order 11738, as amended and where applicable, and Environmental Protection Agency regulations (2 CFR, Part 1500). CITY shall report any violations of these provisions to BBHC and the Regional Office of the Environmental Protection Agency (EPA).

ARTICLE XVIII. DEBARMENT

18.1 CITY represents and warrants that it has never been (1) convicted of a criminal offense related to health care or related to the provision of services paid for by Medicare, Medicaid or another federal health care program; or (2) excluded from participation in any federal health care program, including Medicare and Medicaid. CITY must immediately notify BBHC if any of the foregoing conditions occur. Moreover, CITY certifies that it complies with the provisions of §287.138, Florida Statutes.

18.2 BBHC reserves the right to terminate this Agreement immediately upon notification by CITY, or discovery by BBHC, that any of the foregoing conditions occurred.

ARTICLE XIX. PROTECTED HEALTH INFORMATION

19.1 It is expressly understood by the Parties that each party and their agents have access to protected health information, in any form or electronic media ("PHI") that is subject to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. §§ 160, 162, and 164 and related regulations. To the extent either party will have or be given access to Protected Health Information as part of performing services hereunder, the other party will be deemed a Business Associate of the other party for purposes of this Agreement and will comply with all requirements of a Business Associate under HIPAA. Accordingly, each party will execute the other party's Business Associate Agreement which shall be provided for execution and incorporated herein.

19.2 Each party must fully protect individually identifiable health information as required by HIPAA and, must handle and secure such PHI in compliance with HIPAA and its related regulations and, if required by HIPAA or other laws, include in its "Notice of Privacy Practices" notice of the other party's use of such PHI. The requirement to comply with this provision and HIPAA shall survive the expiration or earlier termination of this Agreement. CITY must ensure that the requirements of this Article are included in all agreements with its sub-consultants.

ARTICLE XX. E-VERIFY

20.1 Unauthorized aliens shall not be employed. BBHC shall consider the employment of unauthorized aliens a violation of section 274A(e) of the Immigration and Nationality Act (8 U.S.C. §1324 a), §101 of the Immigration Reform and Control Act of 1986, and §448.095, Florida Statutes. Such violation shall be cause for unilateral cancellation of this Agreement by BBHC. The Provider and its subcontractors will enroll in and use the E-Verify system established by the U.S. Department of Homeland Security to verify the employment eligibility of its employees and its subcontractors' employees performing under this Agreement located at http://www.uscis.gov/e-verify. The Provider shall certify compliance with these requirements by submittal of the certification contained in **Exhibit "H**."

ARTICLE XXI. NOTICE

21.1 Whenever any party is required to give or deliver any notice to any other party under this Agreement, or desires to do so, such notices shall be in writing and shall be deemed to have been properly given if transmitted by hand-delivery, sent via registered or certified mail with postage prepaid, return receipt requested, or by private postal service, addressed to the parties below:

FOR CONTRACTOR:	City Manager City of Fort Lauderdale 401 SE 21st Street Fort Lauderdale, Florida 33316
With a copy to:	City Attorney 1 East Broward Boulevard Fort Lauderdale, Florida 33301
FOR BBHC:	Silvia Quintana, CEO Broward Behavioral Health Coalition, Inc. 3521 West Broward Boulevard, Suite 206 Lauderhill, Florida 33312
With a copy to:	Julie F. Klahr, General Counsel Goren, Cherof, Doody & Ezrol, P.A. 3099 East Commercial Boulevard, Suite 200 Fort Lauderdale, Florida 33308

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IN WITNESS OF THE FOREGOING, the Parties have set their hands and seals the day and year as provided below:

CITY OF FORT LAUDERDALE, a Florida municipal corporation

By: _____
Susan Grant
Acting City Manager

Date: 1/15/24

ATTEST:

By: _____
David Soloman
City Clerk

Approved as to Legal Form and Correctness:
Thomas J. Ansbro, City Attorney

By: _____
Rhonda Montoya Hasan
Senior Assistant City Attorney

WITNESSES:

Signature

KERLINE ROBINSON
Print Name

Signature

Stefanie Pace
Print Name

BROWARD BEHAVIORAL HEALTH COALITION, INC., a non-profit Florida corporation

By: Silvia M. Quintana
Silva Quintana, Chief Executive Officer

(CORPORATE SEAL)

STATE OF FLORIDA :
COUNTY OF BROWARD :

The foregoing instrument was acknowledged before me by means of ☑ physical presence or ☐ online notarization, this 25TH day of JULY, 2024, by Silva Quintana, Chief Executive Officer for BROWARD BEHAVIORAL HEALTH COALITION, INC., a non-profit Florida corporation.

(Signature of Notary Public – State of Florida)

ALFONSO J. RUIZ
(Print, Type, or Stamp Commissioned Name of Notary Public)

Personally Known ✓ OR Produced Identification ____
Type of Identification Produced_____

ALFONSO DE JESUS RUIZ
Notary Public - State of Florida
Commission # HH 285695
My Comm. Expires Nov 2, 2026
Bonded through National Notary Assn.

{00605842.11 3094-0000000 }

EXHIBIT "A"
Scope of Services

INTRODUCTION

The Broward Behavioral Health Coalition (BBHC) has proposed to fund the City of Fort Lauderdale Fire Rescue Department a sum of $500,000 to organize a 1-year pilot program to target the treatment of opioid addiction. This goal is exciting and fits within our mission to "saving life and property by providing the highest level of emergency services for our community since 1912". The timing of this grant could not come at a better time, over the past year we have already been focusing on frequent callers and addressing needs within our community via our Mobil Integrated Health Program. This new CORE Program will further enhance our ability to help the underserved in our community.

STAFFING MODEL

Paramedic + Community Health Coordinator model

1. One (1) specialty-training Paramedic hired on OT each day for 8 hours
2. One (1) Community Health Coordinator or equivalent, 40-hour workweek, hired as a temporary position for the 1-year pilot program

The paramedic position can be of any rank as long as they have been through the EMS Bureau-approved training. This cohort of personnel will be used to hire for the position through the 1-year pilot program. The Community Health Coordinator will be hired as a temporary position. The language used to fill the current position in the City of Fort Lauderdale will be the template. This single point of contact will aid in creating consistency during the pilot program.

DUTIES

Training/Teaching/Instruction

- Training for the Team will be coordinated with members of BBHC, Broward Health, and Fort Lauderdale Fire Rescue.
- The Team will be responsible for providing the initial training for medication administration to Operations crews. This initial training will center on the majority of the Operations division and focus on paramedics assigned to the medical rescue unit (MRU). Maintenance training will be as needed.

Outreach/Marketing

- Outreach and marketing would highlight the collaboration between entities and shine a light on our goal of tackling the opioid crisis in Fort Lauderdale.
- The Team will utilize all social media platforms authorized by the FLFR PIO to aid those in need. They will attend all relevant events and tailor their schedule to be physically present at locations identified as areas with high numbers of overdoses.
- A strong collaboration with FLPD and other law enforcement agencies is required. Law enforcement may have a stronger network of understanding for individuals who may need treatment.

Co-Response

- The Team will respond to all overdoses that occur during their normal working hours. The Team will follow the established SOP and coordinate with the ED for follow-up opportunities. If there are any delays in responding to the scene, the Team will meet the MRU at the ED. The Team will then meet the patient at the ED for an introduction.

Hospital Interaction

- The Team will regularly interact with hospital staff and those patients transported to the ED that overdosed to establish contact and coordinate treatment and follow-up.

Follow-Up:

The Team will determine the intervals needed to follow-up with clients enrolled in the program. This will be spelled out in the SOP and will range from patient assessment, patient education, and medication administration.

Data Collection

- The Team will collect all relevant data into the patient/client tracking software platform.

Meetings

- The Team will meet twice monthly as defined by the SOW.

MAT INCLUSION CRITERIA

a. The patient must be conscious, answer questions appropriately, and express a desire for assistance.
b. Opiate abuse with history of overdose or recent opioid overdose, active withdrawals from opioid requesting assistance.
c. Has a known address or a location where they can be found for the next 7-21 days.
d. Agrees to Program visits and calls.
    - Visits and calls at 30, 60, 90, 180, and 360-day points for evaluation.
e. The patient's age is equal to or greater than 18 years old.
f. Has no known allergies to buprenorphine or Narcan.
g. Is not currently on Methadone.
h. The patient is willing to sign a Medication Assisted Treatment (MAT) consent form.

MAT EXCLUSION CRITERIA

a. Patient currently receiving Methadone.
b. Has a positive pregnancy test or is breastfeeding (this does not exclude, but medical control must be informed).
c. If pregnant, will refer to Broward Health MAT program.
d. Acute psychosis or suicidality
e. The patient uses opioids for a medical condition (physician prescribed).
f. The patient requires hospital admission for acute care.
g. Is in the custody of Law Enforcement.
h. Is under the age of 18.

i. Refuses to sign a medical release form and the Medication Assisted Treatment (MAT) consent form.

FIELD RESPONSE PROTOCOL AND PROCEDURE

Acute overdose

a. Refer to FLFR Medical Protocols and transport to Broward Health
b. ED management to stabilize.
c. MAT consult and psychiatric assessment if indicated.
d. ED Peer Specialist or ED Physician gives warm handoff to CORE Program in ED if inclusion/exclusion criteria are met.
e. Provide program information packet and Narcan before discharge.
f. 24-hour post-discharge follow-up with CORE Team
g. Broward Health Mental Health referral if indicated.

Opiate response calls

a. 24 hour/7 day a week access point for referrals
b. Assess the desire to initiate treatment.
c. Determine if patient meets MAT inclusion/exclusion criteria.
d. Calculate a Clinical Opiate Withdrawal Scale (COWS Assessment).
e. Proceed to appointment scheduling and Broward Health Behavioral Health follow-up.
f. Counsel patient regarding buprenorphine treatment for withdrawal
g. Assess desire to initiate treatment and discuss treatment options.
h. Administer buprenorphine sub-lingual.
i. Repeat the COWS Assessment (the goal is to obtain a score of less than 5).
j. Administer buprenorphine in 4 mg increments every 15 minutes or until all objective signs of withdrawal are resolved.
k. Provide counseling and support services.
l. Broward Health Behavioral Health referral if indicated.
m. Schedule a follow-up appointment with the CORE team.

LONGITUDINAL CARE

1. The FLFR Response Team will visit the subject for up to 14 days.
   - A referral for more intensive services will be recommended by the FLFR CHC if necessary.
2. On days 2-7, the FLFR personnel will administer the established medication assisted therapy dose daily. (At their prescheduled appointment time frame).
3. Once the patient has completed the 7-day course of MAT and has been referred to an addiction/behavioral health facility for further care, contact will be made at 30, 60, 90, and 180 days to verify that the client has continued services and remains drug-free.

Broward Behavioral Health Coalition, Inc.

BUDGET

Amt	Item	Cost	Fringe 25%	Total
1	Sworn Personnel	$ 244,986		$ 244,986
1	Civilian CHW	$ 58,000	$ 14,500	$ 72,500
2	Tablet (iPad)	$ 650		$ 1,300
1	Marketing material	$ 25,000		$ 25,000
1	Vehicle	$ 55,100		$ 55,100
1	Wrap	$ 3,000		$ 3,000
1	Light package	$ 4,000		$ 4,000
1	Radio (portable)	$ 14,000		$ 14,000
2	Radio (mobile)	$ 8,000		$ 16,000
1	LP15	$ 50,000		$ 50,000
2	Laptop	$ 1,350		$ 2,700
2	Docking Stations	$ 180		$ 360
1	Uniforms	$ 5,000		$ 5,000
1	Color Printer	$ 600		$ 600
2	Keyboard/Mouse	$ 70		$ 140
2	Office Equipment	$ 950		$ 1,900
2	Monitor	$ 180		$ 360
2	iPhone	$ 1,000		$ 2,000
2	Office Phone	$ 350		$ 700
2	Webcams	$ 65		$ 130
1	Office Supplies	$ 224		$ 224
	TOTAL	**$ 472,705**		**$ 500,000**

Broward Behavioral Health Coalition, Inc.

Proposed Outcomes and Quarterly Deliverables FY 23-24

Quarter 1

a. Purchase the vehicle
b. Finalize protocol and procedures for EMS Responses to Opiate Calls
c. Hiring and Training staff, including data entry portion
d. Ensure all logistical supports are in place
e. Start proving the EMS Services
f. Start tracking outcomes
g. Start entering data in the DCF selected data system (as applicable)

Quarter 2

a. Finalize Hiring and Training staff, including data entry portion
b. Continue proving the EMS Services
c. Continue tracking outcomes
d. Continue entering data in the DCF selected data system (as applicable)

Quarter 3 and following Quarters

a. Continue proving the EMS Services
b. Continue tracking outcomes
c. Continue entering data in the DCF selected data system (as applicable)

Please refer to DCF Guidance Document #41 for additional program requirements, responsibilities, and additional details.

Broward Behavioral Health Coalition, Inc.

EXHIBIT "B"

RATE SCHEDULE

RATE	COST
Year 1 - $37,075 per month (1 month)	**$500,000 Cost of Vehicle = $55,100 Balance = $444,900**
Year 2 - $37,075 per month (12 months)	**$444,900**
Year 3 - $28,160.42 per month (12 months)	**$337,925**

NOTE: This funding is based on DCF's allocation:

- $500,000 for Year 1
- $250,00 of Year 2
- $125,000 for Year 3

The above schedule has been prorated based on the start of the contract and BBHC's fiscal year.

Broward Behavioral Health Coalition, Inc.

EXHIBIT "C"
REQUIRED INSURANCE

Pursuant to Article IX of Agreement, and this Exhibit "C," CITY agrees to provide the following policies of insurance which must include the following coverage and minimum limits of liability, or provide written verification that CITY is self-insured in accordance with Florida law.

1. **COMMERCIAL GENERAL LIABILITY INSURANCE** including, but not limited to coverage for premises & operations, personal & advertising injury, products & completed operations, Liability assumed under an Insured Contract (including tort liability of another assumed in a business contract), and independent contractors. Coverage must be written on an occurrence basis, with limits of liability no less than:
    a. Each Occurrence Limit - $1,000,000
    b. Fire Damage Limit (Damage to rented premises) - $100,000
    c. Personal & Advertising Injury Limit - $1,000,000
    d. General Aggregate Limit - $2,000,000
    e. Products & Completed Operations Aggregate Limit - $2,000,000

    Products & Completed Operations Coverage shall be maintained for two (2) years after the final payment under this Agreement.

2. **WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE** covering all employees, and/or volunteers of the CITY engaged in the performance of the scope of work associated with this Agreement. In the case any work is sublet or subcontracted, the CITY shall require the subcontractors similarly to provide Workers Compensation Insurance for all the latter's employees unless such employees are covered by the protection afforded by the CITY. Coverage for the CITY and his subcontractors shall be in accordance with applicable state and/or federal laws that may apply to Workers' Compensation Insurance with limits of liability no less than:

a.	Worker's Compensation	Statutory
b.	Employer's Liability	$500,000 each accident $500,000 Disease-policy limit $500,000 Disease-each employee

    If CITY claims to be exempt from this requirement, CITY shall provide BBHC with proof of such exemption along with a written request for BBHC to exempt CITY, written on CITY's letterhead.

3. **AUTO LIABILITY INSURANCE** covering all owned, leased, hired, non-owned and employee non-owned vehicles used in connection with the performance of work under this Agreement, with a combined single limit of liability for bodily injury and property damage no less than:

    a. Comprehensive Form - $500,000
    b. Any Auto (Symbol 1)
       Combined Single Limit (Each Accident) - $1,000,000
    c. Hired Autos (Symbol 8)
       Combined Single Limit (Each Accident) - $1,000,000
    c. Owned Auto - $500,000
    d. Non-Owned Autos (Symbol 9)
       Combined Single Limit (Each Accident) - $1,000,000

4. **PROFESSIONAL LIABILITY/ERRORS & OMISSIONS INSURANCE** with a limit of liability no less than $1,000,000 per wrongful act with a deductible not to exceed $100,000 per claim. This coverage shall be maintained for a period of no less than ten (10) years after final payment of the contract.

5. **EXCESS LIABILITY / UMBRELLA**

6. **REQUIRED ENDORSEMENTS**

    a. "Broward Behavioral Health Coalition, Inc." shall be named as an Additional Insured on each of the polices required herein

    b. Waiver of all Rights of Subrogation against BBHC

    c. 30 Day Notice of Cancellation or Non-Renewal to BBHC

    d. CONTRACTOR's policies shall be Primary & Non-Contributory

    e. All policies shall contain a "severability of interest" or "cross liability" liability clause without obligation for premium payment by BBHC.

Broward Behavioral Health Coalition, Inc.

EXHIBIT "D"
BBHC Conflict of Interest Policy

Broward Behavioral Health Coalition, Inc.	
Policy Title: Conflict of Interest	
Policy Number: BBHC.0025	**Contract: JH343**
Effective Date: 5/16/2013	**Revision Date: 7/24/2023**
Responsible Department: Administration	

Approved by: D[illegible] anaging Director of Administration
Signature: DocuSigned by: Danica Mamby 7149EC975596488... Date: 7/24/2023

Approved by: Si[illegible] ef Executive Officer
Signature: DocuSigned by: Silvia Quintana D999499950A143C... Date: 7/24/2023

Policy:
It is the policy of Broward Behavioral Health Coalition, Inc. (BBHC) to implement a conflict of interest policy to protect the organization's interest when considering entering into a transaction or arrangement that might benefit the private interest of an officer, director, or staff of the organization or might result in a possible excess benefit transaction.

Purpose:
The purpose of this policy is to clarify conflict of interest by BBHC staff and Board of Directors as it relates to BBHC's business matters and outside consulting.

Conflict of interest in BBHC business matters and outside consulting are covered in two separate sections:

A. BUSINESS MATTERS

a. **PURCHASES** – BBHC does not purchase goods or services directly or indirectly from its employees and staff, other than those which are specified in the condition of employment with BBHC. If an unusual situation arises which might warrant consideration of such a transaction, it must be reviewed and approved by the CEO of BBHC or a designated representative of BBHC.

b. **SALES** – BBHC does not sell services or materials to its employees and staff for their personal use except for items which are normally sold, or services provided by BBHC or BBHC subcontracted providers.

c. **GIFTS** - The association between providers and BBHC employees and staff should always be on a professional and business-like basis. Gratuities from providers to BBHC employees or staff are not to be accepted by BBHC

employees and staff. Staff shall discourage the offer of, and decline, individual gifts, or gratuities of value in any way that might influence the purchase of supplies, equipment, and/or services. Staff shall notify their immediate supervisor if they are offered such gifts. Additionally, in accordance with contractual obligations, BBHC employees or staff will not offer to give or give any gift to any DCF employee.

d. **SELECTION, AWARD OR ADMINISTRATION OF A CONTRACT OR GRANT** - No BBHC employee or staff shall participate in the selection, award, or administration of a contract involving BBHC including, but not limited to a contract supported by state or federal funds, if a real or apparent conflict of interest would be involved. Such a conflict would arise when the employee, officer, or agent, or any member of her or his immediate family, his or her partner, or an organization that employs or is about to employ any of the parties indicated herein, has a financial or other interest in the firm selected. If there is a conflict of interest, the employee must report it and exclude him or herself from participating in the proceedings. Documentation of this reporting and exclusion from the proceedings will be kept on file at BBHC as long as records are retained for the transactions in question. No gratuities may be solicited or received by employees in the administration of a contract. Gratuities may not be solicited or accepted in the administration of a contract or grant.

e. **SELECTION OR ADMINISTRATION OF A VENDOR** - No BBHC employee or staff shall participate in the selection or administration of a vendor if a real or apparent conflict of interest would be involved. Such a conflict would arise if an employee or staff, or any member of his/her immediate family, his/her spouse/partner, or an organization that employs or is about to employ any of the parties indicated herein, has a financial or other interest in the vendor selected.

f. **GRATUITIES** – Gratuities may not be solicited from vendors. Unsolicited gifts of a nominal value of $50 or less may be accepted with the approval of the CEO from vendors.

B. CONSULTING

a. BBHC employees and staff may accept opportunities for outside consulting and similar services in their fields of specialization or expertise, provided this work does not interfere or conflict with their BBHC work responsibilities. BBHC employees and staff may not profit from private services while receiving compensation from BBHC for the performance of these same services. The time involved in consulting activities shall be during non-BBHC working hours, i.e., vacation, holidays, weekends, etc.

b. BBHC assumes no responsibility for private professional services rendered by BBHC employees and staff. When BBHC employees perform services in a private capacity, they must make it clear to those who employ them that they are not acting as agents of BBHC.

c. If BBHC facilities, staff or equipment are used in any activity, the activity must be a BBHC authorized function and must be conducted under either a contract with BBHC or an agreement whereby BBHC is reimbursed for facilities, staff or equipment used in conducting this activity.

d. BBHC employees and staff should not advertise for consulting work using the name of BBHC.

e. Any challenge by BBHC personnel of rulings by their immediate Supervisors on the substance or extent of their consulting should be made to the CEO of BBHC.

NETWORK PROVIDERS

BBHC's Network service providers must have procedures to disclose and resolve conflicts of interest.

REFERENCES:

ATTACHMENTS:
Conflict of Interest Questionnaire

DEFINITIONS:

REVISION/REVIEW LOG	**DATE**
Added more verbiage to ensure the policy is more applicable to staff and not just to BBHC Board.	1/19/2018
Minor grammatical changes	9/25/2020
Added Conflict of Interest Questionnaire	7/23/2021
Added verbiage regarding network providers' need for Conflict of Interest Procedures	9/15/2021
No change	7/21/2022
Changed Director of Administration to Managing Director of Administration	7/24/2023

The Managing Director of Administration and Chief Executive Officer are responsible for all content in this policy.

Broward Behavioral Health Coalition, Inc.

EXHIBIT "E"
BBHC Provider Handbook

FY 23-24 BBHC Provider Contract Handbook

Table of Contents

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I. Introduction

This is the Broward Behavioral Health Coalition, Inc. (BBHC) Provider Contract Handbook referenced in your contract. You will be notified of any changes to this Handbook. This handbook contains programmatic and policy information for services managed by BBHC according to DCF Managing Entity (ME) guidelines. Please refer to your contract with BBHC for specifics, as only those programs and services that pertain to your contract apply to your provider agency.

Remainder of page is intentionally left blank

II. Service Provision Detail

A. SERVICES TO BE PROVIDED

1. Definition of Terms

The definitions of certain terms used in this Contract can be found in the Broward Behavioral Health Coalition, Inc. ("ME" or "BBHC") Definition of Terms, which is incorporated herein by reference and available on the BBHC website at www.bbhcflorida.org.

2. General Description

a. General Statement

The services provided under this Contract are community-based Substance Abuse and Mental Health ("SAMH") services for a person-centered and family-focused coordinated system of care. The Contract requires the qualified, direct service, community-based Provider to provide services for adults and/or children with behavioral health issues as authorized in §394.9082, Florida Statutes, consistent with Chapters 394, 397, 916, and §985.03, Florida Statutes (as applicable), State Behavioral Health Services Plan dated January 2011, or the latest version thereof, and in the ME contract with the Florida Department of Children & Families ("DCF") ("Prime Contract"), which is incorporated herein by reference and which may be found on BBHC's website.

The Provider shall work in partnership with the ME to meet the needs of individuals, hereinafter referred to as person served, with co-occurring substance abuse and mental health disorders and in need of trauma informed care. The partnership process will be open, transparent, dynamic, fluid, and visible. The process shall also serve as an opportunity for collaboration to continuously improve the quality of services provided to the residents of Broward Country. During the term of the Contract, the ME will require that the Provider participate in the process of improving co-occurring disorder service capability system-wide and in trauma informed care services. The Provider shall participate in the ME's initiatives, as applicable. To which the ME shall advise, notify, or train the Provider, as deemed appropriate and follow all BBHC's Policies and Procedure which are located at www.bbhcflorida.org and is incorporated herein by reference, in the fulfillment of its contractual obligations and to assist the ME in the fulfillment of its contractual obligations as required in the Prime Contract in the following areas:

(1) System of Care Development and Management;
(2) Utilization Management;
(3) Quality Improvement;
(4) Data Collection, Reporting, and Analysis;
(5) Financial Management; and
(6) Disaster Planning and Responsiveness

b. Scope of Services

The following scope of service applies to the Contract:

(1) The Provider is responsible for the administration and provision of services to the target person served indicated in exhibit entitled "Person Served" and in accordance with the tasks outlined in this Contract. Services shall be delivered at the locations specified in and in accordance with the Provider's ME-approved Application for Pre-Qualification and Program Description which are incorporated herein by reference.

(2) Services shall be delivered in Broward County, Florida.

c. Major Program Goals

(1) The primary goal is to promote the reduction of substance use, abuse, and dependence and improve the mental health and lives of the people of Broward County by making substance abuse and mental health treatment and support services available through a comprehensive, integrated community-based System of Care, and to engage and encourage persons with, or at-risk of, substance abuse and/or mental illness to live, work, learn, and participate fully in their community.

(2) It is the goal of the ME to improve accountability; ensure quality of care through evidence-based practices ("EBP") and ensure delivery of behavioral health services available through the ME Provider Network and across systems resulting in systematic access to a full continuum of care for all children and adults who enter the publicly-funded behavioral health services systems.

(3) It is the goal to improve co-occurring capability, trauma informed care, and expertise in all programs.

(4) To promote and improve the behavioral health of Broward County by strategically applying substance abuse prevention programs and environmental strategies relevant to community needs through the delivery of substance abuse, mental health and prevention services.

d. Minimum Programmatic Requirements

The Provider shall maintain the following minimum programmatic requirements:

(1) System of Care:
The recovery oriented system of care must be consumer and family-driven and will:

- **(a)** Be driven by the needs and choices of the person served;
- **(b)** Promote family and personal self-determination and choice;
- **(c)** Be ethically, socially, and culturally/linguistically responsive and responsible; and
- **(d)** Be dedicated to excellence and quality results.

There is a commitment to expand clinical treatment to include the behavioral health EBP and recovery support services in accordance with priorities established by the ME for substance abuse, mental health treatment and/or co-occurring disorders, substance abuse prevention services, substance abuse and mental health treatment capacity, children and families, criminal and juvenile justice, HIV and hepatitis.

(2) Guiding Principles
All services delivered by the Provider shall:

- **(a)** Include the person served and families as full partners in the planning and delivery of services;
- **(b)** Incorporate a broad array of service and support (e.g. physical, emotional, clinical, social, educational, and spiritual);
- **(c)** Meet the person served individualized needs and strengths;
- **(d)** Be provided in the least restrictive clinically appropriate setting;
- **(e)** Be coordinated at the system and service delivery level to ensure multiple services are seamlessly provided;
- **(f)** Be sensitive to cultural and linguistic needs of person served; and
- **(g)** Be gender responsive, e.g., treatment services designed to meet the needs of women.

3. Persons to be Served

Behavioral Health services shall be provided to persons pursuant to §394.674, Florida Statutes, including those individuals who have been identified as requiring priority by state or federal law. These identified priorities include, but are not limited to, the categories in sections (a) through (j), below. Persons in categories (a) and (b) are specifically identified as persons to be given immediate priority over those in any other categories.

a. Pursuant to 45 C.F.R.§96.131, priority admission to pregnant women and women with dependent children by providers receiving Substance Abuse Prevention and Treatment ("SAPT") Block Grant funding;

b. Pursuant to 45 C.F.R. §96.126, compliance with interim services, for injection drug users, by providers receiving SAPT Block Grant funding and treating injection drug users;

c. Priority for services to families with children determined to require substance abuse and mental health services by child protective investigators and also meet the target person served in subsections (a) or (b), above. Such priority shall be limited to individuals not enrolled in managed care or another insurance program, or require services not paid by another payor source, as applicable:

(1) Parents or caregivers in need of adult mental health services pursuant to §394.674(1)(a)2, Florida Statutes, based upon the emotional crisis experienced from the potential removal of children; and

(2) Parents or caregivers in need of adult substance abuse services pursuant to §394.674(1)(c)3, Florida Statutes, based on the risk to the children due

to a substance use disorder.

d. Individuals who reside in civil and forensic state Mental Health Treatment Facilities and individuals who are at risk of being admitted into a civil or forensic state Mental Health Treatment Facility pursuant to §394.4573, Florida Statutes, and Rules 65E-15.031 and 65E-15.071, F.A.C.;

e. Individuals who are voluntarily admitted, involuntarily examined, or placed under Part I, Chapter 394, Florida Statutes;

f. Individuals who are involuntarily admitted under Part V, Chapter 397, Florida Statutes;

g. Residents of assisted living facilities as required in §§394.4574 and 429.075, Florida Statutes;

h. Children referred for residential placement in compliance with Rule 65E-9.008(4), F.A.C.;

i. Inmates approaching the End of Sentence pursuant to Children and Families Operating Procedure ("CFOP") 155-47; and

j. In the event of a Presidential Major Disaster Declaration, Crisis Counseling Program ("CCP") services shall be contracted for according to the terms and conditions of any CCP grant award approved by representatives of the Federal Emergency Management Agency ("FEMA") and the Substance Abuse and Mental Health Services Administration ("SAMHSA").

4. Determination of Individuals Served

BBHC may delegate determinations to the Provider, subject to the provisions of the Paragraph entitled "Contract Document" of the Contract.

a. In no circumstances shall an individual's county of residence be a factor that denies access to service.

b. The Provider shall attest on its monthly invoice submitted to BBHC/Carisk, that at the time of submission, no other funding source was known for the invoiced services.

c. DCF, in accordance with state law, is exclusively responsible for defining Individuals Served for services provided through this Contract. In the event of a dispute, the determination made by the BBHC as directed by DCF is final and binding on all parties.

B. MANNER OF SERVICE PROVISION

1. Service Tasks: The following tasks must be completed during the term of the Contract:

Task List

(1) Based on person served needs, the Provider agrees to provide appropriate services from the list of approved programs/activities described in exhibit, entitled "Service Detail" and the description of such services detailed in the "Application for Pre-Qualification and Program Description". No changes in the array of services shall be made unless prior written approval is furnished by the ME.

(2) The Provider shall serve the number of persons indicated in exhibit, entitled "Person Served" within the activities specified in "Service Detail" exhibit.

(3) The Provider shall ensure EBP are accessible to person served and fidelity maintained by the Provider as described in the Provider's Quality Assurance/Improvement Plan, incorporated herein by reference. The Provider's EBPs, as applicable, will be reviewed by the ME as part of its annual monitoring activities and the Provider agrees to make revisions when the ME determines there is a need.

(4) The Provider shall adhere to treatment group size limitations not to exceed fifteen (15) individuals per group for any clinical therapy service provided. In addition to other programmatic documentation requirements, service documentation to evidence group activities shall include the following:

(a) Data Elements:

- **i.** Service Documentation-Group Sign in Sheet;
- **ii.** Recipient name and identification number;
- **iii.** Staff name and identification number;
- **iv.** Service date;
- **v.** Start time;
- **vi.** Duration;
- **vii.** Covered Service;
- **viii.** Brief description of type of group; and
- **ix.** Program (AMH, ASA, CMH, CSA)

(b) Audit Documentation-Recipient Service/Non-Recipient Chart:

- **i.** Recipient name and identification number or if non-recipient;
- **ii.** Participant's name, address, and relation to recipient;
- **iii.** Staff name and identification number;
- **iv.** Service date;
- **v.** Duration; and
- **vi**. Group progress note

(5) For licensable services, the Provider shall maintain correct and current Florida Agency for Health Care Administration ("AHCA") licenses and only

bill for services under those licenses. In the event any of the Provider's licenses are suspended, revoked, expired or terminated, the Provider shall provide immediate written notification to the ME's Contract Manager listed in Number 6 of the Standard Contract. Payment shall be suspended for services delivered by the Provider under such license(s) until said license(s) are reinstated.

(6) If the Provider provides medication management services, it shall ensure person served discharged from state mental health treatment facilities will be maintained on the medication prescribed to the person served by the facility at discharge pursuant to §394.676, Florida Statutes. Maintenance includes performing required lab tests, providing the medication, and providing appropriate physician oversight.

(7) Continuous Quality Improvement Programs: The Provider shall adhere to its Continuous Quality Improvement ("CQI") program included in the Provider's Application for Pre-Qualification and accepted by the ME. The Provider shall ensure the implementation of the Program to monitor and evaluate the appropriateness and quality of care; ensure services are rendered consistently with prevailing professional standards; and to identify and resolve problems objectively and systematically. Additionally, the program must support activities to ensure fraud, waste, and abuse does not occur.

(8) Performance Measures for Continuous Quality Improvement Programs: The Provider shall track by program, as applicable, the performance measures as specified in the **"**Performance Measures for CQI Programs" exhibit.

(9) Trauma Informed Care ("TIC"): The Provider's services shall be delivered in a manner that addresses the impact of trauma on the persons' served development; adjustment; and treatment. This includes comprehensive assessment tools to identify whether the person served is impacted by trauma and appropriate services to successfully treat the persons served.

(10) Recovery Oriented System of Care (ROSC): The Provider shall participate in this initiative through the BBHC Clinical/Quality Improvement Committee which will include the integration of Mental Health and Substance Abuse services. Providers are required to ensure staff are trained and are implementing the ROSC framework.

(11) Cultural and Linguistic Competence: The Provider shall adhere to its Cultural and Linguistic Plan submitted and approved by the ME. The Provider will maintain strategies to increase cultural competence among board members, staff; and family members, when appropriate and ensure person served access that address cultural and linguistic needs and preferences, including but not limited to sign language, Spanish, Creole, translation, and interpretive services.

(12) Medication Assisted Treatment (MAT): A requirement to discuss the

option of medication-assisted treatment with individuals with opioid use disorders or alcohol use disorders.

- For individuals with opioid use disorders, the Network Service Provider shall discuss medication-assisted treatment using FDA-approved medications including but not limited to methadone, buprenorphine, and naltrexone.
- For individuals with alcohol use disorders, the Network Service Provider shall discuss medication-assisted treatment using FDA-approved medications including but not limited to Naltrexone (Vivitrol) Injections funded through The Florida Alcohol and Drug Abuse Association (FADAA). A requirement to actively link individuals to medication-assisted treatment providers upon request of the individual served;
- A prohibition on a denial of an eligible individual's access to the Network Service Provider's program or services based on the individual's current or past use of FDA-approved medications for the treatment of substance use disorders. Specifically, this must include requirements to:
  - Ensure the Network Service Provider's programs and services do not prevent the individual from participating in methadone treatment rendered in accordance with current federal and state methadone dispensing regulations from an Opioid Treatment Program when ordered by a physician who has evaluated the person served and determined that methadone is an appropriate medication treatment for the individual's opioid use disorder;
  - Permit the individual to access medications for FDA-approved medication-assisted treatment by prescription or office-based implantation if the medication is appropriately authorized through prescription by a licensed prescriber or provider.
  - Permit the individuals access to the services permitted below.
  - Permit continuation in medication-assisted treatment for as long as the prescriber or medication-assisted treatment provider determines that the medication is clinically beneficial; and
  - Prohibit compelling an individual to no longer use medication-assisted treatment as part of the conditions of any program or services if stopping is inconsistent with a licensed prescriber's recommendation or valid prescription.

(13) Institutional Review Board ("IRB"): The ME requires the Provider comply with CFOP 215-8, Oversight of Human Subject Research and Institutional Review Board Determination and obtain the prior written approval of the ME for all research conducted by the Provider or any of its employees; contracted organizations; or individuals, or any public or private vendor, even if the aforementioned has their own IRB which has granted approval. CFOP 215-8 is available on the ME website at www.bbhcflorida.org and incorporated herein by reference.

(14) The Provider shall participate in the ME's Peer Review process, when implemented, to assess the quality, appropriateness, and efficacy of services provided to individuals pursuant to 45 CFR §96.136.

(15) The Provider shall maintain a current MOU with the appropriate Federally Qualified Health Center ("FQHC") or hospital district that provides for the integration of primary care services to the medically underserved. The Provider shall submit to the ME's Contract Manager an updated MOU within five (5) calendar days of the effective date of any changes to the MOU on file with the ME.

The Provider shall conduct primary health care screenings, including blood pressure and BMI (waist circumference), as appropriate, unless the type of service prevents it or a waiver is provided by the ME.

(16) **Access to Care:** The Provider shall ensure individuals needing treatment services will receive services, depending on the severity of individual need, consistent with industry standards for distance and travel time, and as specified in the ME Utilization Management ("UM") protocol, is which is incorporated herein by reference. Non-compliance with timely access to care for services terms will result in a corrective action and may result in a financial penalty as specified in the Paragraph entitled "Financial Penalties for Failure to Take Corrective Action" of the Contract. Further, the Provider shall ensure the needs and preferences of persons served and their families drive treatment planning and service delivery, and persons served and their families (with consent) are involved in all aspects of treatment (pre, during and post); engage persons served , family members, and advocates in the design, development, and evaluation of services; provide persons served with a choice of provider and services, whenever possible; and continuously assess and improve consumer satisfaction.

(17) **Clients with special needs:** The Provider shall assess the persons served to identify whether specialty services apply including: employability skills training; victimization and trauma; infant mental health; elderly; family; recovery; blind, deaf, or hard of hearing; developmentally disabled; and criminally-involved/forensic. When specialty services are identified as a need and not delivered by the Provider, the Provider shall link the persons served to an appropriate service agency, engage the service agency in treatment planning and service delivery, as appropriate. As applicable, the Provider shall provide early diagnosis and treatment intervention to enhance recovery and prevent hospitalization and collaborate with the ME and other stakeholders to reduce the admissions and the length of stay for dependent children and adults with mental illness in residential treatment services.

(18) **Develop and Disseminate Consumer Manual:** The Providers shall make available to all persons served and persons served family members a copy of the BBHC Consumer Manual, which includes information about access procedures; recipient rights and responsibilities; and grievance and appeal procedures. A copy of the BBHC Consumer Manual is available at www.bbhcflorida.org, and is incorporated herein by reference.

(19) Work and Social Opportunities: The Provider will employ Peer Specialist to develop work and social opportunities for persons served and make recommendations to the ME for a consumer-driven system

(20) Assist Stakeholder Involvement in Planning, Evaluation, and Service Delivery:

(a) Provider will assist the ME in engaging local stakeholders, pursuant to §394.9082, Florida Statutes;

(b) Providers shall implement DCF's Recovery Oriented System of Care initiative by affording and ensuring meaningful opportunities for participation of persons served, their families, and peers in governance or advisory bodies of Provider's organization, providing training for their complete participation in such governance activities, and affording meaningful and full participation in the Provider's strategic planning, decision making, governance, implementation, and evaluation of Provider's programs, system of care, and services;

(c) Provider shall work with the ME to provide performance, utilization, and other information as may be required of the ME by DCF.

(21) Client Satisfaction Survey: The Provider shall conduct and submit quarterly Consumer Satisfaction Surveys of persons served. The ME will advise the Provider in writing by July 31st each contract year of the total number of Consumer Satisfaction Surveys that will be required to be submitted quarterly by the Provider for that contract year. Failure to provide the required number of surveys may result in a corrective action and an imposed financial penalty.

(22) Utilization Management: The Provider agrees to participate in all of the requirements of the ME Utilization Management Program as detailed in at www.bbhcflorida.org, and incorporated herein by reference.

(23) Client Trust Funds ("CTF"):

(a) If the Provider is the representative payee for Supplemental Security Income ("SSI"); Social Security Administration ("SSA"); Veterans Administration ("VA"); or other federal benefits on behalf of the persons served, the Provider shall comply with the applicable federal laws including the establishment and management of individual persons served trust accounts (20 CFR §416 and 31 CFR §240). The Provider shall also maintain and submit documentation of all payment/fees received on behalf of ME persons served receiving SSI; SSA; VA; or other federal benefits upon request from the ME.

(b) Any Provider assuming responsibility for administration of the personal property and/or funds of persons served shall follow DCF's Accounting Procedures Manual 7 APM, 6, Volume 7, incorporated herein by reference (available from DCF). The ME; DCF; their designees; or duly authorized individuals may review all records

relating to this section. Any shortages of persons served funds attributable to the Provider as determined by the ME shall be repaid by the Provider, plus interest as provided in §55.03, Florida Statutes, within one (1) week of the determination.

(24) Complaints and Grievances: The Provider shall adhere to its ME-approved Complaints and Grievances Policy and Procedures whereby persons served may submit complaints and/or grieve concerns about contracted services delivered by the Provider through a progressive response within the Provider's organization that results in timely resolution and ultimately appeal to the ME for a final determination. The Provider shall ensure all written materials include the telephone number for the ME (1-877-698-7794) to which consumers, family members, employees, and the public may report grievances, persons served, and staff receive annual training topic evidenced through documentation of successful completion of training in the employee's Personnel File. Persons served and family members shall also be advised of the Provider Policy at intake for services.

(25) The ME and/or DCF have the right to review the Provider's policies, procedures, and plans as they may apply to this Contract. Once reviewed by the ME and/or DCF, the policies and procedures, may be amended provided they conform to state and federal laws, rules and regulations. Substantive amendments to submitted policies, procedures and plans shall be provided to the ME.

(26) The Provider shall provide an annual update to the 2-1-1 Broward Information and Referral Call Center site directly, and within seven (7) business days when program information changes. For instructions to update your agency's information, please contact 2-1-1 Broward or update online at http://www.211-broward.org. Updating provider program information is critical to ensure that a current and centralized information and referral point for services is available to the residents of Broward County. Provider must provide confirmation that 2-1-1 information has been updated annually prior to contract execution.

(27) Integration Task Limits: The Provider shall perform all services under this Contract in accordance with applicable federal, state and local rules, statutes, licensing standards, and policies and procedures. Furthermore, the Provider agrees to abide by the approved documents submitted in its Application for Pre-Qualification and Program Description, and is not authorized by the ME to perform any tasks related to the Contract other than those described therein without the express written consent of the ME.

(28) Suicide Prevention**, Treatment and Postvention:** BBHC is participating in the Broward County Suicide Prevention Collaborative. Providers will be asked to participate as applicable in the development and implementation of recommendations that result from this effort.

BBHC is developing a network wide suicide framework, based on the Zero Suicide Initiative. Providers will be expected to implement the principles that BBHC deems fundamental to ensuring appropriate for the management of suicide prevention, treatment and postvention, within the network.

2. Staffing Requirements

a. Staffing Levels

(1) The Provider shall maintain staffing levels in compliance with applicable professional qualifications, rules, statutes, licensing standards and policies and procedures. See "Minimum Service Requirements" exhibit, which can be located on the BBHC website at www.bbhcflorida.org and is incorporated herein by reference.

(2) The Provider shall engage in recruitment efforts to employ capable and competent staff with the ethnic and racial diversity demonstrated by the persons served. The ME may request documentation evidencing Provider's recruitment efforts in compliance with this requirement.

(3) The Provider shall adhere to applicable BBHC Credentialing Program requirements as detailed in the BBHC Credentialing Policy, which can be located on the BBHC website at www.bbhcflorida.org and is incorporated herein by reference.

b. Professional Qualifications

The Provider shall ensure its staff successfully complete screening for all mental health personnel; substance abuse personnel; chief executive officers; owners; directors; and chief financial officers according to the standards for Level II screening set forth in Chapter 435, and §408.809, Florida Statutes, except as otherwise specified in §394.4572(1)(b)-(c), Florida Statutes; and are of good moral character. For the purposes of this Contract, "mental health personnel" includes all program directors; professional clinicians; staff members; and volunteers working in public or private mental health programs and facilities that have direct contact with individuals held for examination or admitted for mental health treatment. Screening for substance abuse personnel shall be conducted in accordance with the standards set forth in Chapter 397, Florida Statutes. This requirement shall include all personnel who have direct contact with children receiving services or with adults who are developmentally disabled receiving services.

c. Staffing Changes

The Provider shall provide written notification to the ME within (10) calendar days of any staffing changes in the positions of Chief Executive Officer; Chief Financial Officer; Medical Director; Clinical Director; IT Director; Dispute Resolution Officer; Data Security Officer; Single Point of Contact in accordance with Section 504 of the Rehabilitation Act of 1973 as required by the Paragraph entitled "Additional Requirements of Law, Regulation, and Funding Source" of the Contract, or any individuals with similar functions.

3. Service Location and Equipment

a. Service Delivery Location and Times

The location, days and times of services will be as specified in the approved documents submitted in the Provider's approved Application for Pre-Qualification and Program Description. The Provider shall submit a written request for approval to the ME prior to making any changes.

b. Equipment

The Provider shall furnish all appropriate equipment necessary for the effective delivery of the services purchased. In the event the Provider is authorized to purchase any non-expendable property with funds under this Contract, the Provider will ensure compliance with BBHC.0038, Property Management, which can be located at www.bbhcflorida.org, and is incorporated herein by reference; DCF Operating procedures as outlined in CFOP 40-5, CFOP 80-2, and Rule 65E-14, F.A.C., as applicable, which are incorporated herein by reference and may be obtained from the ME.

4. Deliverables

a. Services

The Provider shall deliver the services specified in and described in the approved documents submitted in the Provider's Application for Pre-Qualification and Program Description submitted by the Provider and as set forth in the Service Detail exhibit.

b. Reports and Data Submission

Where this Contract requires the delivery of reports to the ME, mere receipt by the ME shall not be construed to mean or imply acceptance of those reports. The ME reserves the right to reject reports as incomplete, inadequate, or unacceptable according to the Contract and declare this Contract to be in default.

(1) The Provider shall submit treatment data, as set out in §394.74(3)(e), Florida Statutes and Rule 65E-14.022, F.A.C, and FASAMS DCF Pamphlet 155-2, the most recent version.

(2) In addition to the modifiers to procedure codes currently required to be utilized as per the FASAMS DCF Pamphlet 155-2, the most recent version, the Provider is directed to utilize the modifiers required for services funded as described in the OCA Allocation Instructions handout as revised from time to time, as applicable.

(3) In addition to utilizing, the modifiers to procedure codes for block grant funds identified in Section B. 4. b. (2) above, the Provider shall submit information regarding the amount and number of services paid for by the Community Mental Health Services Block Grant and/or the Substance Abuse Prevention and Treatment Block Grant or other Prevention services utilizing exhibit, entitled "Outreach/Prevention Services Activities Log" and upon request by the ME.

(4) Data shall be submitted electronically to the ME by the 7th of each month following the month of service into the DCF designated prevention database or other data reporting system designated by the ME (the "Portal"). As per the Subcontractor Financial Responsibility Policy #BBHC.0045, Providers are responsible for the quality of their data; therefore, errors in authorizations/certifications and penalties due to exceptions or data errors will result in payment adjustments, regardless if the Provider has banked/excess units. The Provider shall also:

(a) Ensure the data submitted clearly documents all persons served admissions, discharges, and any required clinical form follow-ups which occurred under this Contract and substance abuse prevention services data entered into PBPS (or other data reporting system designated by the ME) and that it clearly documents all program participants, programs and strategies which occurred under this Contract, as applicable;

(b) Ensure all data submitted to Carisk Portal (or other data reporting system designated by the ME) is consistent with the data maintained in the Provider's persons served files and substance abuse prevention services data entered into PBPS (or other data reporting system designated by the ME) is consistent with the data maintained in the Provider files, if applicable;

(c) Acute Care Services: Florida State legislation mandates that Acute Care Providers perform daily submission of Acute Services Census to the Managing Entities. The Managing Entity (ME) and Carisk have designed an acute services data collection and reporting system that makes compliance with the Legislative mandates as easy as possible for those facilities that have been contracted by the ME to provide acute services. This mandate applies to utilization of all acute care licensed beds regardless of funding. The data must be submitted daily; a Provider is required to submit at any time of the day the required data from the previous day. The data from Friday, Saturday, and Sunday can be submitted on Monday.

i. Alternative Method: As per FASAMS DCF Pamphlet 155-2, the most current version, an enrollment record is required for a persons served specific service records be accepted in the system, when funded by DCF. Since this requirement may disrupt the daily submission, the Provider Portal has a funding source code named 'Z- Temp Crisis Svcs'. Using this code, person served-specific service events does not require an enrollment record. However, providers will need to

reconcile and update these records with the appropriate funding source code with the monthly submission of data. At this point, the Provider's Portal will enforce the enrollment requirement, if the selected code is a DCF-funded type. As per the title of this section, this is an Alternative Method of data submission, Providers may prefer not to use this option and send enrollments records with the persons served specific services during the daily submission (recommended option).

ii. Non-DCF/ME funded services: Most Providers have been already uploading both DCF/SAMH funded acute services and Non-DCF/Other Funders acute services using Client Specific Services Form/File (recommended). Non-DCF/Other Funders acute services information is used to show aggregated numbers only and will not be shown in the system screen reports nor be sent to DCF. For Non-DCF/ME funded services only, Providers have the option to report the aggregate number of beds utilized on a specific date and funding source using the Non-Client Specific Service Event Form/File. Since these types of services are measured in days, the fields units and participants must match. In the case that these two fields do not match, Carisk will consider that the 'units' field contains the valid number of occupied beds to be reported to DCF and to be used in the generation of reports. Note that ME has only approved reporting using the Non-Client Specific Form/File when the complete episode of care of the persons served is paid by 3rd party Funders. If a persons served has at least one service in the episode of care funded by the ME/DCF; the complete services dataset must be reported using the Client-Specific Form/File.

(d) In order for DCF to assign a unique identifier according to Florida Statute 394.9082(3)(h) DCF is mandating the DEMO Forms within five business (5) days of initial intake or admission. For simplification, the DEMO Forms must be uploaded on Fridays for all persons served admitted that week.

(e) Review the ME's File Upload History screen in the Carisk Apps Portal to determine the number of records accepted, updated and rejected. Based on this review, the Provider shall download any associated error files to determine which persons served records were rejected and to make sure that

the rejected records are corrected and resubmitted in the Carisk Apps Portal on or before the 7th of the month.

(f) Resubmit corrected records no later than the next monthly submission deadline. The failure to submit any data set or the Provider's total monthly submission per data set, which results in a rejection rate of 5% or higher of the number of monthly records submitted will require the Provider to submit a corrective action plan describing how and when the missing data will be submitted or how and when the rejected records will be corrected and resubmitted; and

(g) In accordance with the provisions of §402.73(1), Florida Statutes, and Rule 65-29.001, F.A.C., corrective action plans may be required for non-compliance, nonperformance, or unacceptable performance under this Contract. Penalties may be imposed for failures to implement or to make acceptable progress on such corrective action plans. Failure to implement corrective action plans to the satisfaction of the ME and after receiving due notice, shall be grounds for Contract termination.

(h) The submission of reports or documentation required by this Contract for which the Provider is not able to meet the deadlines due to a BBHC technical issue may be extended upon receipt of a written extension request by the Provider to BBHC. Extensions will be considered on a case-by-case basis and does not absolve the Provider from its responsibilities herein.

(5) A facility designated as a public receiving or treatment facility under this Contract shall report the following Payor Class data to the ME, unless such data are currently being submitted into the Carisk Apps Portal. Public receiving or treatment facilities that do not submit data into the Carisk Apps Portal, or other data reporting system designated by the ME, shall report these data annually as specified in the Required Reports exhibit, even if such data are currently being submitted to AHCA:

- **(a)** Number of licensed beds available by payor class;
- **(b)** Number of contract days by payor class;
- **(c)** Number of persons served (unduplicated) in program by payor class and diagnoses;
- **(d)** Number of utilized bed days by payor class;
- **(e)** Average length of stay by payor class; and
- **(f)** Total revenues by payor class.

(6) The Provider shall obtain the format and directions for submitting Payor Class data from the ME.

(7) The Provider shall submit Payer Class data to the ME by the date specified in the Required Reports exhibit**.** The final submittal under this Contract shall be submitted to the ME no later than 90 days following the end of the ME's fiscal year (June 30).

(8) The Provider must subtract all units, which are billable to other sources, including Social Security, Medicare payments, managed care, and funds eligible for local matching which include patient fees from first, second, and third-party payers, from each monthly request for payment. Should an overpayment be detected upon reconciliation of payments, the Provider shall immediately refund any overpayment to the ME.

5. Performance Specifications

a. Performance Measures

The Provider shall meet the performance standards and required outcomes as specified in the Substance Abuse & Mental Health Required Performance Outcomes & Outputs exhibit. The Provider agrees the Carisk Apps Portal; PBPS; SAMHIS; and any other data reporting system designated by the ME, will be the sources for all data used to determine compliance with performance standards and outcomes in Output Measures exhibit. Any conflict will be resolved by the ME and the Provider shall adhere to the ME's determination. The Provider shall submit all service related data for persons served funded in whole or in part by SAMH funds, local match, managed care or other funders. In addition to the performance standards and required outcomes specified in Output Measures exhibit, the Provider shall meet requirements set forth in Section D under Service Provision Detail, of this Handbook, entitled "Special Provisions."

b. Performance Evaluation Methodology

The Provider shall collect information and submit performance data and individual persons served outcomes, to the ME data system in compliance with FASAMS DCF Pamphlet 155-2, most recent version requirements. The Provider shall maintain the capability to engage in organized performance improvement activities, and to be able to participate in partnership with the ME in performance improvement projects related to system wide transformation and improvement of services for individuals and families. If the Provider fails to meet the Contract standards, the ME, at its exclusive option, may allow a reasonable period for the Provider to correct performance deficiencies. If performance deficiencies are not resolved to the satisfaction of the ME within the prescribed time, the ME will terminate the Contract. Performance data information is posted on DCF's website.

6. Provider Responsibilities

a. Provider Unique Activities

(1) By executing this Contract, the Provider recognizes its responsibility for the tasks, activities, and deliverables described herein, warrants it

has fully informed itself of all relevant factors affecting the accomplishment of the tasks, activities and deliverables, and agrees to be fully accountable for the performance thereof whether performed by the Provider or its subcontractors.

(2) The Provider shall ensure invoices submitted to the ME reconcile with the amount of funding and services specified in this Contract, as well as the Provider's agency audit report and persons served information system and reconciled with the Carisk Apps Portal, PBPS, or other data reporting system designated by the ME. If the Provider receives Incidental funding from BBHC, it shall complete the "Incidental Fund Invoice and Expenditure Log for Adult Mental Health Services" exhibit and submit on a monthly basis as supporting documentation for the invoice.

(3) If the Provider receives federal block grant funds from the Substance Abuse Prevention and Treatment or Community Mental Health Block Grants the Provider agrees to comply with Subparts I and II of Part B of Title XIX of the Public Health Service Act, 42 U.S.C. §300x-21, et seq. (as approved September 22, 2000) and the Health and Human Services (HHS) Block Grant regulations (45 CFR Part 96).

(4) If the Provider receives funding from the Substance Abuse Prevention and Treatment Block Grant ("SAPT") it shall maintain compliance with all of the requirements of the Substance Abuse and Mental Health Services Administration ("SAMHSA") Charitable Choice provisions and the implementing regulations of 42 CFR §54a.

(5) The Provider shall be engaged in performance improvement activities to improve its ability to recognize accurate prevalence of co-occurring disorders in its data system.

(6) The Provider shall provide additional performance information or reports other than those required by this Contract at the request of the ME as may be required by other funding or regulatory agencies.

(7) The Provider shall cooperate with the ME, DCF and other duly authorized representatives of the ME and federal and state representatives when investigations are conducted regarding a regulatory complaint of the Provider as it pertains to the services provided under this Contract.

(8) The Provider shall be responsible for the fiscal integrity of all funds under this Contract, and for demonstrating a comprehensive audit and tracking system exists to account for funding by persons served, and have the ability to provide an audit trail. The Provider's financial management and accounting system must have the capability to generate financial reports on individual service recipient utilization, cost, claims, billing, and collections for the ME. The Provider must maximize all potential sources of revenue to increase services, and

institute efficiencies that will consolidate infrastructure and management functions in order to maximize funding.

(9) The Provider shall make available to the ME all evaluations, assessments, surveys, monitoring or other reports and any corrective action plans, related to behavioral health programs, pertaining to outside licensure, accreditation, or other reviews conducted by funding entities or others and received from such other entities within ten (10) business days of receipt by Provider. The Provider shall implement a process for tracking all corrective action plans and submit a copy of the tracking log to the ME upon request.

(10) The Provider shall maintain human resource policies and procedures that provide safeguards to ensure compliance with laws, rules and regulations, and integrate current or new state and federal requirements and policy initiatives into its operations upon provision by the ME of the same.

(11) The Provider shall make available source documentation of units billed by Provider upon request from the ME. The Provider shall track all units billed to the ME by program and by Other Cost Accumulator ("OCA").

(12) The Provider will demonstrate efforts to initiate and support local county implementation of the Medicaid Substance Abuse Local Match Program in order to expand community service capacity through draw down of federal funding.

(13) The Provider shall maintain in one place for easy accessibility and review by ME all policies, procedures, tools, and plans adopted by the Provider. The Provider's policies, procedures, and plans must conform to state and federal laws, regulations, rules, and minimally meet the expectations and requirements contained in applicable ME and DCF operating procedures as they may pertain to the services provided under this Contract.

(14) The Provider shall maintain a mechanism for monitoring, updating, and disseminating policies and procedures regarding compliance with current government laws, rules, practices, regulations, and the ME's policies and procedures.

b. Coordination with other Providers/Entities

1. In its role as an Adult Mental Health and or Adult Substance Abuse service provider, Provider agrees to cooperate with ME in the development and maintenance of care coordination and integrated care systems that address the provision of appropriate services to persons who have behavioral health problems and leave the criminal justice system. Additionally, Provider shall cooperate with ME in the development and implementation of cooperative agreements with

other external stakeholders involved in the care, treatment, and success of adult mental health and adult substance abuse individuals.

2. Plan for Care Coordination

(i) The Provider agrees to coordinate services with other providers and state entities rendering services to children, adults, and families, as applicable, as the need is identified by the ME;

(ii) When indicated by the ME, the Provider will ensure substance abuse and/or mental health services are available to persons served by the Broward Sheriff's Office's ("BSO") Protective Investigators to support the principle of keeping children in the home whenever possible. Priority for behavioral health services shall be given to families with children determined to be "unsafe" by the BSO's child protective investigators. Such priority is limited to individuals who are not eligible for managed care, or who require services not included as reimbursable by managed care, as defined in Person Served exhibit.

The failure of other providers or entities does not relieve the Provider of accountability for tasks or services the Provider is obligated to perform pursuant to this Contract.

c. Minimum Service Requirements: See "Minimum Service Requirements" exhibit.

7. Managing Entity Responsibilities

a. Managing Entity Obligations

(1) The ME is solely responsible for the oversight of the Provider and enforcement of all terms and conditions of this contract. Any and all inquiries and issues arising under this Contract are to be brought solely and directly to the ME for consideration and resolution between the Provider and the ME. In any event, the ME's decision is final on all issues and subject to the ME's appeal process and legal rights of the Provider.

(2) The ME is responsible for the administration, management, and oversight of subcontracts and the provision of behavioral health services in Broward County through its subcontracted providers. This also includes statewide beds as specified in the Prime Contract, and in this Contract.

(3) The ME will approve standardized tools and assessments, which must be used to determine placement and level of care for all persons served.

b. Monitoring Requirements

(1) The ME will monitor the Provider in accordance with this Contract and ME's monitoring Policy and related procedures entitled Contract/Program Monitoring policy (BBHC.0081) which can be located at www.bbhcflorida.org and is incorporated herein by reference. The Provider shall comply with any coordination or documentation required by the ME to successfully evaluate the programs, and shall provide complete access to all records, including budget and financial information, related to services provided under this Contract, regardless of the source of funds.

(2) At the sole discretion of the ME, if there is a threat to health, life, safety or well-being of clients, the ME may require immediate corrective action or take such other action, as the ME deems appropriate. Failure to implement corrective action plans to the satisfaction of the ME and after receiving due notice, shall be grounds for Contract termination in whole or in part.

c. Training and Technical Assistance

(1) The ME will provide technical assistance and support to the Provider to ensure the continued integration of services and support for persons served, to include but not limited to quality improvement activities to implement EBP treatment protocols; the application of process improvement methods to improve the coordination of access; and services that are culturally and linguistically appropriate.

(2) The ME will provide technical assistance and support to the Provider for the maintenance and reporting of data on the performance standards that are specified in Output Measures exhibit.

(3) The ME may implement a training program for its staff and the Provider staff. The trainings assure that staff receives externally mandated and internal training. The ME may coordinate training or directly provide training to Provider staff.

d. Review Compliance with Utilization Management Criteria

(1) As part of the quality improvement program, the ME will provide or coordinate reviews of service compliance with criteria and practice guidelines, such as retrospective reviews to ensure the level of placement of clients is appropriate. The ME will take corrective action to resolve situations in which the Provider is not following the guidelines or working to help the system meet its utilization goals. Providers shall comply with the requirements and protocols for "Utilization Management", which is located on the ME website at www.bbhcflorida.org and is incorporated herein by reference.

(2) The ME may request supporting documentation and review source documentation of units billed to the ME.

e. Juvenile Incompetent to Proceed Program:
The ME will manage the Juvenile Incompetent to Proceed ("JITP") Program pursuant to §985.19, Florida Statutes and DCF's operating procedures. In addition, the ME will ensure all youth involved with the JITP program are linked with the appropriate mental health services and reduce the time to access treatment services.

f. Residential Level 1 Services
The ME will ensure Residential Level 1 is available to youth in the community. The ME will establish a comprehensive assessment process to determine when youth are most appropriately served within residential facilities or in their home. The ME will establish a system of intensive in-home services for the most severely disturbed youth and families as an alternative to residential facilities.

C. Compensation:

1. The Provider shall be paid in accordance with the terms contained in the following exhibits as completed by the appropriate party and as more particularly set forth in Section VII "Method of Payment" herein below:

Method of Payment
Invoice, which is located in the Carisk Apps Portal
Service Detail
Funding Detail
Local Match Plan

D. Special Provisions

1. The Provider shall not charge the ME an administrative cost in excess of **9.99%** of the total Contract amount.

2. Incident Reports

a. The Provider shall submit incident reports that meet eligibility criteria to the ME and enter into the Incident Reporting and Analysis System ("IRAS") pursuant to the ME's Incident Reporting Policy and Procedure entitled, "BBHC.0013, Critical Incident Reporting" which is located at www.bbhcflorida.org and is incorporated herein by reference. The Provider and any subcontractor must comply with and inform its employees of the mandatory reporting requirements. The Provider is advised certain incidents may warrant additional follow-up by the ME, which may include on-site investigations or requests for additional information or documentation. When additional information or documentation is requested, the Provider shall submit the information requested by the ME as required above. It is the responsibility of the Provider to maintain an Incident Reporting Logbook listing all incidents reported by the Provider, with the following information: persons' served initials, incident report tracking number from IRAS (if applicable), incident report category, date and time of incident, and follow-up action taken.

b. All Providers (inpatient and outpatient) will report seclusion and restraint events in SAMHIS and in accordance with Rule 65E-5.180(7) (g), F.A.C.

3. Mental Health providers shall participate in DCF's aftercare referral process for formerly incarcerated individuals with severe and persistent mental illness or serious mental illness who are released to the community or who are determined to be in need of long-term hospitalization. Participation shall be as specified in CFOP 155-47, "Processing Referrals from the Department Of Corrections" which can be located at www.bbhcflorida.org and is incorporated herein by reference.

4. **Involuntary Outpatient Placements:** If referred, the Provider shall deliver services to persons who have been court ordered into involuntary outpatient placement in accordance with §394.4655, Florida Statutes

5. **Children's Mental Health Services, including services for Severely Emotionally Disturbed Children, Emotionally Disturbed Children and their Families, if services to such consumers are offered:** The key strategic objectives and strategies that support DCF's mission and direct the provision of services to Florida's residents are detailed in the Substance Abuse and Mental Health Services Plan 2014-2016, or the latest revision thereof, which is incorporated herein by reference.

Providers shall comply with the DCF Standards regarding "Children's Mental Health Services."

6. **Service Provision Requirements for Substance Abuse Prevention and Treatment Block Grants, if applicable.**

(a) The Provider agrees to comply with the data submission requirements outlined in FASAMS DCF Pamphlet 155-2, most recent version and with the funding restrictions outlined in "SAMH OCA's and Funding Restrictions" and which are incorporated herein by reference.

(b) The Provider is required to utilize the modifiers to procedure codes required for Block Grant funds as per FASAMS DCF Pamphlet 155-2, most recent version.

(c) The Provider agrees to comply with applicable data submission requirements outlined in Required Reports exhibit.

(d) The Provider shall make available, either directly or by arrangement with others, tuberculosis services to include counseling, testing, and referral for evaluation and treatment.

(e) The Provider shall use SAPT funds provided under this Contract to support both substance abuse treatment services and appropriate co-occurring disorder treatment services for individuals with a co-occurring mental disorder only if the funds allocated are used to support substance abuse prevention and treatment services and are tracked to the specific substance abuse activity as listed in Service Detail exhibit.

7. The Provider agrees to maximize the use of state residents, state products, and other Florida-based businesses in fulfilling its contractual duties under this Contract.

8. **Option for Increased Services:** The Provider acknowledges and agrees the Contract may be amended to include additional, negotiated services as deemed necessary by the ME. Additional services can only be increased when the Provider demonstrates competence in the provision of contractual services and meets the criteria established by the ME. The ME shall determine in its sole discretion at what time and to which Provider and in what amount is to be given to Providers for additional services.

9. **Sliding Fee Scale:** The ME requires the Provider to comply with the provisions of Rule 65E-14.018, Florida Administrative Code. The Provider shall adhere to the Sliding Fee Scale submitted in its approved Application for Pre-Qualification and Program Description and submit an annual update to the ME.

10. **Transportation Disadvantaged:** The Provider agrees to comply with the provisions of chapter 427, Florida Statutes, Part I, Transportation Services, and Chapter 41-2, Florida Administrative Code, Commission for the Transportation Disadvantaged, if public funds provided under this Contract will be used to transport person served. The Provider agrees to comply with the provisions DCF operating procedure CFOP 40-5, Acquisition of Vehicles for Transporting Disadvantaged Person served if public funds provided under this Contract will be used to purchase vehicles, which will be used to transport person served.

11. **Medicaid Enrollment**

    (a) Those providers with a Contract that meet Medicaid MMA provider criteria and with funding in excess of $500,000 annually shall enroll as a Medicaid MMA provider within ninety (90) days of Contract execution. A waiver of the ninety (90) day requirement may be obtained through the ME.

    (b) All providers whose contracts are $500,000 or more annually and enrolled as a Medicaid MMA provider shall participate in the Medicaid Administrative Claiming program as required AHCA and DCF.

    (c) Participation in the Medicaid Administrative Claiming program is optional for those Substance Abuse and Mental Health providers who are enrolled as Medicaid MMA providers with contract amounts less than $500,000 annually, and who have the technological capability to participate electronically.

    (d) As applicable, the Provider shall comply with changes to Medicaid effective July 1, 2014, or as may be further amended thereafter.

12. **National Provider Identifier ("NPI"):** The Provider shall obtain and use an NPI, a HIPAA standard unique health identifier for health care providers.

13. **Ethical Conduct:** The Provider hereby acknowledges it understands performance under this Contract involves the expenditure of public funds from both the state and federal governments, and that the acceptance of such funds obligates the Provider to perform its services in accordance with the very highest standards of ethical conduct. No employee, director, officer, agent of the Provider shall engage in any

business, financial or legal relationships that undermine the public trust, whether the conduct is unethical, or lends itself to the appearance of ethical impropriety. Providers' directors, officers or employees shall not participate in any matter that would inure to their special private gain or loss and shall recuse themselves accordingly. Public funds may not be used for purposes of lobbying, or for political contributions, or for any expense related to such activities, pursuant to the Paragraph entitled "Additional Requirements of Law, Regulation, and Funding Source" of the Contract. The Provider understands that the ME is mandated to conduct business in the Sunshine, pursuant to section 286.011, Florida Statutes, and chapter 119, Florida Public Records Law, and that all issues relating to the business of the ME and the Provider are public record and subject to full disclosure, except as may be set forth in an exception to the Public Records Laws. The Provider understands that attempting to exercise undue influence on the ME, DCF, and either of their employees to allow deviation or variance from the terms of this Contract other than a negotiated, publicly disclosed amendment, is prohibited by the State of Florida, pursuant to §286.011, Florida Statutes. The Provider's conduct is subject to all State and federal laws governing the conduct of entities engaged in the business of providing services to government.

14. **Information Technology Resources:** If applicable, the Providers must receive written approval from the ME prior to purchasing any Information Technology Resource (ITR) with Contract funds. The Provider will not be reimbursed for any ITR purchases made prior to obtaining the ME's written approval.

15. **Programmatic, Fiscal & Contractual Contract File References:** All of the documentation submitted by the Provider which may include, but not be limited to the Provider's original proposal, Program Description, Projected Covered Service Operating and Capital Budget, Agency Capacity Report and Personnel Detail Record, are herein incorporated by reference for programmatic, contractual and fiscal assurances of service provision as applicable. These referenced contractual documents will be part of the ME's file. The terms and conditions of this Contract shall prevail over those documents incorporated by this reference in the Contract.

16. **Employee Loans:** Funds provided by the ME to the Provider under this Contract shall not be used by the Provider to make loans to their employees, officers, directors and/or subcontractors. Violation of this provision shall be considered a breach of contract and the termination of this Contract shall be in accordance with the Paragraph entitled "The Following Termination Provisions Apply to this Contract" of the Contract. A loan is defined as any advancement of money for which the repayment period extends beyond the next scheduled pay period.

17. **Travel:** The Provider's internal procedures will assure that: travel voucher Form DFS-AA-15, State of Florida Voucher for Reimbursement of Traveling Expenses, incorporated herein by reference, be utilized completed and maintained on file by the Provider. Original receipts for expenses incurred during officially authorized travel, items such as car rental and air transportation, parking and lodging, tolls and fares, must be maintained on file by the Provider. Section 287.058(1)(b), Florida Statutes, requires bills for any travel expense shall be maintained in accordance with §112.061,

Florida Statutes, governing payments for traveling expenses. CFOP 40-1, Official Travel of State Employees and Non-Employees, provides further explanation, clarification, and instruction regarding the reimbursement of traveling expenses necessarily incurred during the performance of business. The Provider must retain on file documentation of all travel expenses to include the following data elements: name of the traveler, dates of travel, travel destination, purpose of travel, hours of departure and return, per diem or meals allowance, map mileage, incidental expenses, signature of payee and payee's supervisor.

18. Property and Title to Vehicles

a. Property

(1) Nonexpendable property is defined as tangible personal property of a non-consumable nature that has an acquisition value or cost of $1,000 or more per unit and an expected useful life of at least one year, and hardback covered bound books that are not circulated to students or the general public, the value or cost of which is $250 or more. Hardback books with a value or cost of $100 or more should be classified as nonexpendable property only if they are circulated to students or to the general public. All computers, including all desktop and laptop computers, regardless of the acquisition cost or value are classified as nonexpendable property. Motor vehicles include any automobile, truck, airplane, boat or other mobile equipment used for transporting persons or cargo.

(2) When government-funded property will be assigned to a provider for use in performance of a contract, the title for that property or vehicle shall be immediately transferred to the Provider where it shall remain until this Contract is terminated or until other disposition instructions are furnished by the ME's contract manager. When property is transferred to the Provider, the ME shall pay for the title transfer. The Provider's responsibility starts when the fully accounted for property or vehicle is assigned to and accepted by the Provider. Business arrangements made between the Provider and its subcontractors shall not permit the transfer of title of state property to subcontractors. While such business arrangements may provide for subcontractor participation in the use and maintenance of the property under their control, the ME shall hold the provider solely responsible for the use and condition of said property. Provider inventories shall be conducted in accordance with DCF operating procedure CFOP 80-2.

(3) If any property is purchased by the Provider with funds provided by this Contract, the Provider shall inventory all nonexpendable property including all computers. A copy of which shall be submitted to the ME along with the expenditure report for the period in which it was purchased. At least annually, the Provider shall submit a complete inventory of all such property to the ME whether new purchases have been made or not.

(4) The **Provider Inventory List,** provided by the ME upon request, and incorporated herein by reference, shall include, at a minimum, the identification number; year and/or model, a description of the property, its use and condition, current location, the name of the property custodian, class code (use state standard codes for capital assets), if a group, record the number and description of the components making up the group, name, make, or manufacturer, serial number(s), if any, and if an automobile, the VIN and certificate number; acquisition date, original acquisition cost, funding source, information needed to calculate the federal and/or State share of its cost.

(5) The ME must provide disposition instructions to the Provider prior to the end of the Contract. The Provider cannot dispose of any property that reverts to the ME without the ME's approval. The Provider shall furnish a Closeout Inventory Form no later than 30 days before the completion or termination of this Contract. The Closeout Inventory Form shall include all nonexpendable property including all computers purchased by the Provider. The Closeout Inventory Form shall contain, at a minimum, the same information required by the annual inventory.

(6) The Provider hereby agrees all inventories required by this Contract shall be current and accurate and reflect the date of the inventory. If the original acquisition cost of a property item is not available at the time of inventory, an estimated value shall be agreed upon by both the Provider and the ME and shall be used in place of the original acquisition cost.

(7) Title (ownership) to and possession of all property purchased by the Provider pursuant to this Contract shall be vested in the ME upon completion or termination of this Contract. During the term of this Contract, the Provider is responsible for insuring all property purchased by or transferred to the Provider is in good working order. The Provider hereby agrees to pay the cost of transferring title to and possession of any property for which ownership is evidenced by a certificate of title. The Provider shall be responsible for repaying to the ME the replacement cost of any property inventoried and not transferred to the ME upon completion or termination of this Contract. When property transfers from the Provider to the ME, the Provider shall be responsible for paying for the title transfer.

(8) If the Provider replaces or disposes of property purchased by the Provider pursuant to this Contract, the Provider is required to provide accurate and complete information pertaining to replacement or disposition of the property as required on the Provider's annual inventory.

(9) To the extent permitted by State law, the Provider hereby agrees to indemnify the ME and DCF against any claim or loss arising out of the operations of any motor vehicle purchased by or transferred to the

Provider pursuant to this Contract.

(10) A formal contract amendment is required prior to the purchase of any property item not specifically listed in the approved Contract budget.

b. Title to Vehicles

(1) Title (ownership) to, and possession of, all vehicles acquired with funds from this Contract shall be vested in the ME upon completion or termination of the Contract. The Provider will retain custody and control during the Contract period, including extensions and renewals.

(2) During the term of this Contract, title to vehicles furnished by using state or federal funds shall not be vested in the Provider. Subcontractors shall not be assigned or transferred title to these vehicles. To the extent permitted by State law, the Provider hereby agrees to indemnify the ME and DCF against any claim or loss arising out of the operations of any motor vehicle purchased by or transferred to the Provider pursuant to this Contract.

19. **Certificates of Insurance:** Certificates of Insurance must comply with the requirements found in the Prime Contract including but not limited to, JH343: A-4.2.3, A-4.2.7, A-4.2.8, A-4.2.9, and A-4.2.10.

E. List of Exhibits

The Provider agrees to comply, as applicable, with the exhibits listed below. The following Exhibits or the latest revisions thereof, are incorporated herein by reference, and are located on the BBHC website at www.bbhcflorida.org.

Exhibit Title	Applicable Services	Location
Persons to be Served	All	Handbook
Method of Payment	All	Handbook
Required Reports	All	Handbook
Substance Abuse and Mental Health Required Performance Outcomes (Titled; Output Measures)	All	Contract
Request for Reimbursement (Invoice)	All	Carisk Apps
Minimum Service Requirements	All	Handbook
Service Detail Rates	All	Contract Handbook
Purchased Beds	Residential; Room & Board; SRT; CSU; Detox	Contract
Funding Detail	All	Contract
Local Match Plan	All	Contract

Outreach/Prevention Activities Service Log	Outreach and Prevention Services	BBHC Website
National Voter Registration Monthly Report	Direct Service Providers	Carisk Apps
TANF Program Participant Log	TANF-Funded	BBHC Website
Incidental Fund Invoice and Expenditure Log	Providers with Incidental Funding	BBHC Website/ Carisk Apps
Performance Measures - Continuous Quality Improvement Programs		Handbook
Consumer Satisfaction Survey	Direct Service Providers	DCF and BBHC Website

III. Monitoring and Audits

In addition to reviews of audits conducted in accordance with 2 Code of Federal Regulations (CFR) §§ 200.500- 200.521 and § 215.97, F.S., as revised, the ME may monitor or conduct oversight reviews to evaluate compliance with contract, management and programmatic requirements. Such monitoring or other oversight procedures may include, but not be limited to, on-site visits by the ME, limited scope audits as defined by Uniform Grant Guidance 2 CFR §200, as revised, or other procedures. By entering into this Contract, the recipient agrees to comply and cooperate with any monitoring procedures deemed appropriate by the ME. In the event the ME determines a limited scope audit of the recipient is appropriate, the recipient agrees to comply with any additional instructions provided by the ME regarding such audit. The recipient further agrees to comply and cooperate with any inspections, reviews, investigations, or audits deemed necessary by DCF's inspector general, the state's Chief Financial Officer or the Auditor General.

A. PART I: FEDERAL REQUIREMENTS

The Network Provider shall comply with the provisions of Federal law and regulations including, but not limited to, 2 CFR, Part 200, and other applicable regulations. This part is applicable if the recipient is a State or local government or a non-profit organization as defined in 2 CFR §§ 200.500-200.521, as revised.

If Provider Contract contains $10,000 or more of Federal Funds, the Network Provider shall comply with Executive Order 11246, Equal Employment Opportunity, as amended by Executive Order 11375 and others, and as supplemented in Department of Labor regulation 41 CFR, Part 60 if applicable.

If Provider Contract contains over $100,000 of Federal Funds, the Network Provider shall comply with all applicable standards, orders, or regulations issued under section 306 of the Clean Air Act, as amended (42 U.S.C. § 7401 et seq.), section 508 of the Federal Water Pollution Control Act, as amended (33 U.S.C. § 1251 et seq.), Executive Order 11738, as amended and where applicable, and Environmental Protection Agency regulations (2 CFR, Part 1500). The Network Provider shall report any violations of the above to the ME and the Department.

If Provider Contract provides services to children up to age 18, the Network Provider shall comply with the Pro-Children Act of 1994 (20 U.S.C. § 6081). Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation or the imposition of an administrative compliance order on the responsible entity, or both.

In the event the recipient expends $500,000 *($750,000 for fiscal years beginning on or after December 26, 2014*) or more in Federal awards during its fiscal year, the recipient must have a single or program-specific audit conducted in accordance with the provisions of 2 CFR §§ 200.500-200.521, as revised. The recipient agrees to provide a copy of the single audit to the ME and its contract manager. In the event the recipient expends less than $500,000 *($750,000 for fiscal years beginning on or after December 26, 2014*) in Federal awards during its fiscal year, the recipient agrees to provide certification to the ME and its contract manager that a single audit was not required. In determining the Federal awards expended during its fiscal year, the recipient shall consider all sources of Federal awards, including Federal resources received from the Department of Children & Families, Federal government (direct), other state agencies, and other non-state entities. The

determination of amounts of Federal awards expended should be in accordance with guidelines established by 2 CFR §§ 200.500-200.521, as revised. An audit of the recipient conducted by the Auditor General in accordance with the provisions of 2 CFR Part 200 §§ 200.500-200.521 will meet the requirements of this part. In connection with the above audit requirements, the recipient shall fulfill the requirements relative to auditee responsibilities as provided in 2 CFR § 200.508, as revised.

The schedule of expenditures should disclose the expenditures by contract number for each contract with the ME in effect during the audit period. The financial statements should disclose whether or not the matching requirement was met for each applicable contract. All questioned costs and liabilities due the ME shall be fully disclosed in the audit report package with reference to the specific contract number.

Single Audit Information for Recipients of Recovery Act Funds:

(a) To maximize the transparency and accountability of funds authorized under the American Recovery and Reinvestment Act of 2009 (Pub. L. 111–5) (Recovery Act) as required by Congress and in accordance with 2 CFR 215.21 ''Uniform Administrative Requirements for Grants and Agreements'' and OMB Circular A–102 Common Rules provisions, recipients agree to maintain records that identify adequately the source and application of Recovery Act funds. OMB Circular A–102 is available at http://www.whitehouse.gov/omb/circulars/a102/a102.html.

(b) For recipients covered by the Single Audit Act Amendments of 1996 and OMB Circular A–133, ''Audits of States, Local Governments, and Non-Profit Organizations,'' recipients agree to separately identify the expenditures for Federal awards under the Recovery Act on the Schedule of Expenditures of Federal Awards ("SEFA") and the Data Collection Form (SF–SAC) required by OMB Circular A–133. OMB Circular A–133 is available at https://www.whitehouse.gov/omb/circulars/a133_compliance_supplement_2014. This shall be accomplished by identifying expenditures for Federal awards made under the Recovery Act separately on the SEFA, and as separate rows under Item 9 of Part III on the SF–SAC by CFDA number, and inclusion of the prefix ''ARRA-'' in identifying the name of the Federal program on the SEFA and as the first characters in Item 9d of Part III on the SF–SAC.

(c) Recipients agree to separately identify to each sub-recipient, and document at the time of sub-award and at the time of disbursement of funds, the Federal award number, CFDA number, and amount of Recovery Act funds. When a recipient awards Recovery Act funds for an existing program, the information furnished to sub-recipients shall distinguish the sub-awards of incremental Recovery Act funds from regular sub-awards under the existing program.

(d) Recipients agree to require their sub-recipients to include on their SEFA information to specifically identify Recovery Act funding similar to the requirements for the recipient SEFA described above. This information is needed to allow the recipient to properly monitor sub-recipient expenditure of ARRA funds as well as oversight by the Federal awarding agencies, offices of Inspector General and the Government Accountability Office.

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B. PART II: STATE REQUIREMENTS

This part is applicable if the recipient is a non-State entity as defined by §215.97(2), Florida Statutes.

In the event the recipient expends $500,000 or more in state financial assistance during its fiscal year, the recipient must have a State single or project-specific audit conducted in accordance with §215.97, Florida Statutes; applicable rules of the Department of Financial Services; and Chapters 10.550 (local governmental entities) or 10.650 (nonprofit and for-profit organizations), Rules of the Auditor General. The recipient agrees to provide a copy of the single audit to the ME and its contract manager. In the event the recipient expends less than $500,000 in State financial assistance during its fiscal year, the recipient agrees to provide certification to the ME and its contract manager that a single audit was not required. In determining the state financial assistance expended during its fiscal year, the recipient shall consider all sources of state financial assistance, including state financial assistance received from the ME, other state agencies, and other non-state entities. State financial assistance does not include Federal direct or pass-through awards and resources received by a non-state entity for Federal program matching requirements.

In connection with the audit requirements addressed in the preceding paragraph, the recipient shall ensure that the audit complies with the requirements of Section §215.97(8), Florida Statutes. This includes submission of a financial reporting package as defined by §215.97(2), Florida Statutes, and Chapters 10.550 or 10.650, Rules of the Auditor General.

The schedule of expenditures should disclose the expenditures by contract number for each contract with the ME in effect during the audit period. The financial statements should disclose whether or not the matching requirement was met for each applicable contract. All questioned costs and liabilities due the ME shall be fully disclosed in the audit report package with reference to the specific contract number.

C. PART III: REPORT SUBMISSION

Any reports, management letters, or other information required to be submitted to the ME pursuant to this agreement shall be submitted within **170** days after the end of the Provider's fiscal year or within 30 days of the recipient's receipt of the audit report, whichever occurs first, directly to each of the following unless otherwise required by Florida Statutes:

A. ME for this Contract one (1) electronic copy and management letter, if issued

B. Reporting packages for audits conducted in accordance with Uniform Grant Guidance 2 CFR §200, as revised, and required by Part I of this Contract shall be submitted, when required by § .320(d), Uniform Grant Guidance 2 CFR §200, as revised, by or on behalf of the recipient directly to the Federal Audit Clearinghouse using the Federal Audit Clearinghouse's Internet Data Entry System at:

https://harvester.census.gov/facweb/ and other Federal agencies and pass-through entities in accordance with Uniform Grant Guidance 2 CFR §200, as revised.

D. PART IV: RECORD RETENTION

The recipient shall retain sufficient records demonstrating its compliance with the terms of this Contract for a period of six years from the date the audit report is issued and shall allow the ME or its designee, Chief Financial Officer or Auditor General access to such records upon request. The recipient shall ensure that audit working papers are made available to the ME or its designee, Chief Financial Officer or Auditor General upon request for a period of three years from the date the audit report is issued, unless extended in writing by the ME.

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IV. HIPAA

This Attachment contains the terms and conditions governing the Provider's access to and use of Protected Health Information ("PHI") and provides the permissible uses and disclosures of protected health information by the Provider, also called the "Business Associate."

A. Section 1. Definitions

1.1 Catch-all definitions:
The following terms used in this Attachment shall have the same meaning as those terms in the Health Insurance Portability and Accountability Act ("HIPAA") Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

1.2 Specific definitions:

1.2.1 "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR §160.103, and for purposes of this Attachment shall specifically refer to the Provider.

1.2.2 "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR §160.103, and for purposes of this Attachment shall refer to the Department.

1.2.3 "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

1.2.4 "Subcontractor" shall generally have the same meaning as the term "subcontractor" at 45 CFR §160.103 and is defined as an individual to whom a business associate delegates a function, activity, service, other than in the capacity of a member of the workforce of such business associate.

B. Section 2. Obligations and Activities of Business Associate

2.1 Business Associate agrees to:

2.1.1 Not use or disclose protected health information other than as permitted or required by this Attachment or as required by law;

2.1.2 Use appropriate administrative safeguards as set forth at 45 CFR §164.308, physical safeguards as set forth at 45 CFR §164.310, and technical safeguards as set forth at 45 CFR §164.312; including, policies and procedures regarding the protection of PHI and/or ePHI set forth at 45 CFR §164.316 and the provisions of training on such policies and procedures to applicable employees, independent contractors, and volunteers, that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI and/or ePHI the Provider creates, receives, maintains or transmits on behalf of the Department/Managing Entity;

2.1.3 Acknowledge that (a) the foregoing safeguards, policies and procedures requirements shall apply to the Business Associate in the same manner that such requirements apply to the Department/Managing Entity and (b) the Business Associate's and their Subcontractors are directly liable under the civil and criminal enforcement provisions set forth at Section 13404 of the

HITECH Act and section 45 CFR §§164.500 and 164.502(E) of the Privacy Rule (42 U.S.C.1320d-5 and 1320d-6), as amended, for failure to comply with the safeguards, policies and procedures requirements and any guidance issued by the Secretary of Health and Human Services with respect to such requirements;

2.1.4 Report to covered entity any use or disclosure of protected health information not provided for by this Attachment of which it becomes aware, including breaches of unsecured protected health information as required at 45 CFR §164.410, and any security incident of which it becomes aware;

2.1.5 Notify the Managing Entity's Security Officer, Privacy Officer and the Contract Manager as soon as possible, but no later than three (3) business days following the determination of any breach or potential breach of personal and confidential departmental/Managing Entity data;

2.1.6 Notify the Privacy Officer and Contract Manager within (24) hours of notification by the US Department of Health and Human Services of any investigations, compliance reviews or inquiries by the US Department of Health and Human Services concerning violations of HIPAA (Privacy, Security Breach).

2.1.7 Provide any additional information requested by the Department/Managing Entity for purposes of investigating and responding to a breach;

2.1.8 Provide at Business Associate's own cost notice to affected parties no later than 30 days following the determination of any potential breach of personal or confidential departmental/Managing Entity data as provided in §817.5681, Florida Statutes;

2.1.9 Implement at Business Associate's own cost measures deemed appropriate by the Department/Managing Entity to avoid or mitigate potential injury to any person due to a breach or potential breach of personal and confidential departmental/Managing Entity data;

2.1.10 Take immediate steps to limit or avoid the recurrence of any security breach and take any other action pertaining to such unauthorized access or disclosure required by applicable federal and state laws and regulations regardless of any actions taken by the Department/Managing Entity;

2.1 11 In accordance with 45 CFR §§164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the business associate agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information. Business Associate's must attain satisfactory assurance in the form of a written contract or other written agreement with their business associate's or subcontractor's that meets the applicable requirements of §164.504(e)(2) that the Business Associate or Subcontractor will appropriately safeguard the information. For prior contracts or other arrangements, the provider shall provide written certification that its implementation complies with the terms of 45 CFR §164.532(d);

2.1.12 Make available protected health information in a designated record set to covered entity as necessary to satisfy covered entity's obligations under 45CFR §164.524;

2.1.13 Make any amendment(s) to protected health information in a designated record set as directed or agreed to by the covered entity pursuant to 45 CFR §164.526, or take other measures as necessary to satisfy covered entity's

obligations under 45 CFR §164.526;

2.1.14 Maintain and make available the information required to provide an accounting of disclosures to the covered entity as necessary to satisfy covered entity's obligations under 45 CFR §164.528;

2.1.15 To the extent the business associate is to carry out one or more of covered entity's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the covered entity in the performance of such obligation(s); and

2.1.16 Make its internal practices, books, and records available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance with the HIPAA Rules.

C. Section 3. Permitted Uses and Disclosures by Business Associate

3.1 The Business associate may only use or disclose protected health information covered under this Attachment as listed below:

3.1.1 The Business Associate may use and disclose the Department/Managing Entity's PHI and/or ePHI received or created by Business Associate (or its agents and subcontractors) in performing its obligations pursuant to this Attachment.

3.1.2 The Business Associate may use the Department/Managing Entity's PHI and/or ePHI received or created by Business Associate (or its agents and subcontractors) for archival purposes.

3.1.3 The Business Associate may use PHI and/or ePHI created or received in its capacity as a Business Associate of the Department/Managing Entity for the proper management and administration of the Business Associate if such use is necessary (a) for the proper management and administration of Business Associate or (b) to carry out the legal responsibilities of Business Associate.

3.1 4 The Business Associate may disclose PHI and/or ePHI created or received in its capacity as a Business Associate of the Department/Managing Entity for the proper management and administration of the Business Associate if (a) the disclosure is required by law or (b) the Business Associate (1) obtains reasonable assurances from the person to whom the PHI and/or ePHI is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person and (2) the person agrees to notify the Business Associate of any instances of which It becomes aware in which the confidentiality and security of the PHI and/or ePHI has been breached.

3.1.5 The Business Associate may aggregate the PHI and/or ePHI created or received pursuant this Attachment with the PHI and/or ePHI of other covered entities that Business Associate has in its possession through its capacity as a Business Associate of such covered entities for the purpose of providing the Department/Managing Entity with data analyses relating to the health care operations of the Department/Managing Entity (as defined in 45 C.F.R.§164.501).

3.1.6 The Business Associate may de identify any and all PHI and/or ePHI received or created pursuant to this Attachment, provided that the de-identification process conforms to the requirements of 45 CFR §164.514(b).

3.1.7 Follow guidance in the HIPAA Rule regarding marketing, fundraising and

research located at Sections 45 CFR § 164.501,45 CFR §164.506 and 45 CFR §164.514.

D. Section 4. Provisions for Covered Entity to Inform Business Associate of Privacy Practices & Restrictions

4.1 Covered entity shall notify business associate of any limitation(s) in the notice of privacy practices of covered entity under 45 CFR §164.520, to the extent that such limitation may affect business associate's use or disclosure of protected health information.

4.2 Covered entity shall notify business associate of any changes in, or revocation of, the permission by an individual to use or disclose his or her protected health information, to the extent that such changes may affect business associate's use or disclosure of protected health information.

4.3 Covered entity shall notify business associate of any restriction on the use or disclosure of protected health information that covered entity has agreed to or is required to abide by under 45 CFR §164.522, to the extent that such restriction may affect business associate's use or disclosure of protected health information.

E. Section 5. Termination

5.1 Termination for Cause

5.1.1 Upon the Department/Managing Entity's knowledge of a material breach by the Business Associate, the Department/Managing Entity shall either:

5.1.1.1 Provide an opportunity for the Business Associate to cure the breach or end the violation and terminate the Agreement or discontinue access to PHI if the Business Associate does not cure the breach or end the violation within the time specified by the Department/Managing Entity;

5.1.1.2 Immediately terminate this Agreement or discontinue access to PHI if the Business Associate has breached a material term of this Attachment and does not end the violation; or

5.1.1.3 If neither termination nor cure is feasible, the Department/Managing Entity shall report the violation to the Secretary of the Department of Health and Human Services.

5.2 Obligations of Business Associate upon Termination

5.2.1 Upon termination of this Attachment for any reason, business associate, with respect to protected health information received from covered entity, or created, maintained, or received by business associate on behalf of covered entity, shall:

5.2.1.1 Retain only that protected health information which is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities;

5.2.1.2 Return to covered entity, or other entity as specified by the Department/Managing Entity or, if permission is granted by the Department/Managing Entity, destroy the remaining protected health information that the Business Associate still maintains in any form;

5.2.1.3 Continue to use appropriate safeguards and comply with Subpart C of

45 CFR Part 164 with respect to electronic protected health information to prevent use or disclosure of the protected health information, other than as provided for in this Section, for as long as Business Associate retains the protected health information;

5.2.1.4 Not use or disclose the protected health information retained by Business Associate other than for the purposes for which such protected health information was retained and subject to the same conditions set out at paragraphs 3.1.3 and 3.1.4 above under "Permitted Uses and Disclosures By Business Associate" which applied prior to termination; and

5.2.1.5 Return to covered entity, or other entity as specified by the Department/Managing Entity or, if permission is granted by the Department/Managing Entity, destroy the protected health information retained by business associate when it is no longer needed by business associate for its proper management and administration or to carry out its legal responsibilities.

5.2.1.6 The obligations of business associate under this Section shall survive the termination of this Attachment.

F. Section 6. Miscellaneous

6.1 A regulatory reference in this Attachment to a section in the HIPAA Rules means the section as in effect or as amended.

6.2 The Parties agree to take such action as is necessary to amend this Attachment from time to time as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law.

6.3 Any ambiguity in this Attachment shall be interpreted to permit compliance with the HIPAA Rules.

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V. Cost Reimbursement for Participants of Evidence Based Practice Trainings

Evidence Based Practice trainings are essential for quality improvement of service delivery of BBHC's Provider Network. Those staff that provides direct services and who were paid on a direct contact hour for the time they participate in an Evidence Based Practice training or activity will now be paid on a cost reimbursement basis. The selected participants will be prior authorized by Broward Behavioral Health Coalition prior to the actual attendance at the training. Providers must request approval for training reimbursement from the BBHC CQI Coordinator no later seven (7) calendar days prior to date of training; at that time all required documents described in the policy must be submitted or provider will risk training obtaining approval.

The following hourly rates will be paid to the provider for the time their staff spend participating in the BBHC selected Evidence Based Practice training. This rate is based on the average network salary for the position plus fringe benefits and an allowance for the operational expenses to support the position.

The rates are as follows:

Position Title	Rate
Clinician (Master's level individuals that provide individual, group, assessment, evaluations)	$67.96
Case manager (Bachelor's level mental health/substance use service linkage, supportive employment, assessors, supportive housing, transitional youth Coordinators, any case management function type paid through direct service)	$59.32
Employment Specialists (supported employment, job development, job coaching, any employment related outreach, treatment planning, and support)	$59.32
Housing Specialists (supportive housing, tenancy supports, landlord relations, move in supports, any housing related outreach, treatment planning, and support)	$59.32
TIP Coaches/Transition Facilitators (youth-related treatment planning and linkage to services, housing, employment, personal connections, social supports, school system, DJJ, child welfare, or other transition-age youth needs)	$59.32
Peer Specialist (wellness recovery action planning (WRAP), one on one mentoring, and individuals billed under recovery and support)	$40.11

VI. Person to be Served

A. General Description

The Provider shall furnish services funded by this Contract to the target population(s) as it appears on, Persons Served exhibit.

B. Client/Participant Eligibility

(1) The Provider agrees that all persons meeting the target population descriptions found in Persons Served exhibit are eligible for services based on the availability of resources. A detailed description of each target Service category is contained in §394.674, Florida Statutes, and as described in the FASAMS DCF Pamphlet 155-2, most recent version, based on the availability of resources. FASAMS DCF Pamphlet 155-2, most recent version is incorporated herein by reference.

(2) This Contract precludes the Provider from billing the ME for services provided to Medicaid eligible individuals, which are reimbursable by Medicaid.

(3) Priority for Behavioral Health Services shall be given to families with children determined to be "unsafe" by child protective investigators. Such priority is limited to individuals that are not Medicaid eligible or require services that are not included as reimbursable by Medicaid. Eligibility for services is found, pursuant to:

(a) §394.674(a)(2), Florida Statutes, for adult mental health services for the parents, based upon the emotional crisis experienced from the potential removal of children.

(b) §394.674(c)3., Florida Statutes, Substance abuse eligibility is based on parents who put children at risk due to a substance abuse disorder.

(4) Mental health crisis intervention and crisis stabilization facility services, and substance abuse detoxification and addiction receiving facility services, shall be provided to all persons meeting the criteria for admission, subject to the availability of beds and/or funds.

C. Client/Participant Determination

(1) Determination of persons' served eligibility is the responsibility of the Provider. The Provider shall adhere to the eligibility requirements as specified in the Minimum Service Requirements Document. The ME reserves the right to review the Provider's determination of client eligibility and override the determination of the Provider. When this occurs, the Provider will immediately provide services to the consumer until such time the consumer completes his/her treatment, voluntarily leaves the program, or the ME's decision is overturned as a result of the dispute resolution.

(2) In the event of a dispute as to the ME's determination regarding eligibility, dispute

resolution, as described in the entitled Paragraph "Dispute Resolution" of the Contract, shall be entered into. An eligibility dispute shall not preclude the provision of services to Individuals Served, unless the dispute resolution process reverses the ME's determination. The determination made by the ME is final and binding on all parties.

(3) The ME may delegate the Individuals Served eligibility determinations to the Provider, subject to the determination of the ME.

(4) Participant eligibility (Direct Prevention) and target population eligibility (Community Prevention) shall also be based upon the community action plan or on the relevant epidemiology data.

D. Contract Limits

(1) The Provider is not authorized to bill the ME for more units than are specified in Service Detail Document, or for more units than can be purchased with the amount of funds specified in the Service Detail Document, included as an attachment to the Contract, subject to the availability of funds. An exception is granted at the end of the Contract, when the ME, at its sole discretion, may pay, subject to the availability of funds, the Provider for "Uncompensated Units Reimbursement Funds", in whole or in part, or not at all as determined by the delivery of services in excess of those units of service the ME is required to pay. The ME's obligation to pay under this Contract is contingent upon an annual appropriation by the Legislature and the Contract between the ME and DCF.

(2) The Provider agrees that funds provided in this Contract will not be used to serve persons outside the target population(s) specified in Person Served exhibit. NOTE: Prevention funds allocated to underage drinking programs and activities targeting eighteen (18) to twenty (20) year old individuals may be taken from Adult Substance Abuse Prevention funds.

(3) The provision of services required under this Contract are limited to eligible residents, children, and adults receiving authorized services within the counties outlined in Service Provision Detail, Section A.2.b.(2) and limited by the availability of funds.

(4) The Provider may not authorize or incur indebtedness on behalf of the ME.

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VII. Method of Payment

Invoices shall be submitted in sufficient detail for the completion of a pre-audit and post-audit.

A. Payment Clauses

1. **This is a fixed price (unit cost) contract**. The unit prices are listed under BBHC Rates in this handbook.,. The ME shall pay for contracted services according to the terms and conditions of this Contract as it appears on the Funding Detail exhibit. When services are paid based on deliverables performance will be determined by the Provider delivering and billing for services in excess of those units of service BBHC will be required to pay. BBHC's obligation to pay under this Contract is contingent upon an annual appropriation by the Legislature and the Contract JH343 between BBHC and the Florida Department of Children and Families ("DCF"). Any costs or services eligible to be paid for under any other contract or from any other source are not eligible for payment under this Contract.

2. Aftercare, Intervention, Outpatient, and Recovery Support Services (Substance Abuse) are eligible for special group rates. Group services shall be billed on the basis of a contact hour, at 25% of the Contract's established rate for the individual services for the same covered service. Excluding Outpatient, total hourly reimbursement for group services shall not exceed the charges for fifteen (15) individuals per group. Group size limitations outlined in the current Medicaid Handbook apply to Outpatient group services funded under this Contract.

3. Pursuant to §394.76(3), Florida Statutes, the Provider agrees to provide local matching funds in the amount stated in the Funding Detail.

4. The ME shall reduce or withhold funds pursuant to Rule 65-29.001, F.A.C., if the Provider fails to comply with the terms of this Contract and/or fails to submit client reports and/or data as required in FASAMS DCF Pamphlet 155-2, most recent version, Rule 65E-14, F.A.C., and in accordance with Required Reports exhibit.

5. When the ME finds cause to reduce or withhold funds invoiced by the Provider, the ME will provide written explanation of the reason(s) to the Provider.

6. If the Provider closes or suspends the provision of services funded by this Contract, it agrees to provide the ME with no less than ninety (90) calendar days of notification. Failure to provide written notice of close or suspend services may result in termination of this Contract.

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B. BBHC Rates FY 23-24

Covered Services	Rates for FY23-24
Aftercare - Group	$ 16.74
Aftercare - Individual	$ 66.95
Assessment	$ 98.74
BNET	$ 1,207.29
Case Management	$ 76.91
Community Action Treatment (CAT) Team -Monthly	$ 62,500.00
Crisis Stabilization	$ 431.33
Crisis Support/Emergency	$ 68.84
Day Treatment	$ 56.31
Daycare	
Drop-In/Self Help Centers	$ 49.07
First Episode Team	$ 75.12
Forensic Multidisciplinary Team Monthly	$ 54,333.33
Florida Assertive Community Treatment (FACT) Team (Daily)	$ 27.40
Information Referral	$ 40.04
Incidental Expenses	$ 1.00
In-Home and On-Site	$ 90.55
Inpatient	$ 431.33
Intervention - Group	$ 20.67
Intervention - Individual	$ 82.66
Medical Services	$ 394.03
Medication Assisted Treatment	$ 15.82
Outpatient - Group	$ 24.78
Outpatient - Individual	$ 99.12
Outreach	$ 63.79
Prevention - Indicated	$ 73.47
Prevention - Selective	$ 73.47
Prevention - Universal Direct	$ 73.47
Prevention - Universal Indirect	$ 73.47
Recovery Support - Group	$ 16.50
Recovery Support - Individual	$ 66.00
Residential Level I	$ 273.56
Residential Level II	$ 249.96

Residential Level III	$	154.88
Residential Level IV	$	77.07
Room & Board with Supervision Level I	$	148.58
Room & Board with Supervision Level II	$	123.19
Room & Board with Supervision Level III	$	74.64
Substance Abuse Inpatient Detox	$	396.29
Substance Abuse Outpatient Detox	$	124.72
Supported Employment	$	78.81
Supportive Housing/Living	$	76.03
Treatment Alternatives for Safer Communities (TASC)	$	71.35

C. Additional Release of Funds

At its sole discretion, the ME may approve the release of more than the monthly pro-rated amount when the Provider submits a written request justifying the release of additional funds.

D. Medicaid Billing

1. The ME and the Provider agree DCF, through its contract with the ME, is not a liable as a third party for Medicaid eligible services provided to individuals that meet the eligibility criteria for Medicaid. Authorized Provider services shall be reimbursed in the following order of precedence:

a. Any liable first, second, and/or third party payors;

b. Medicaid, pursuant to §409.910, Florida Statutes, if the individual meets the eligibility criteria for Medicaid, and the service is Medicaid eligible; and

c. DCF through the ME (only if none of the above are available or eligible for payment)

NOTE: Providers should be leveraging funding with other funding sources.

2. The Provider shall identify and report Medicaid earnings separate from all other fees. Medicaid earnings cannot be used as local match.

3. The Provider shall ensure Medicaid payments are accounted for using generally accepted accounting practices and in adherence to federal and State laws, rules and regulations.

4. In no event shall both Medicaid and the ME be billed for the same service.

5. Providers operating a residential treatment facility licensed as a crisis stabilization unit (“CSU”); detoxification facility (“Detox”); short-term residential treatment (“SRT”) facility; residential treatment facility Levels 1 or 2; or therapeutic group home with greater than sixteen (16) beds are not permitted to bill or knowingly access Medicaid Fee For-Service programs for any services with the exception of case management for individuals eligible for Medicaid while in these facilities.

6. A provider operating a children's residential treatment center of greater than 16 beds is not permitted to bill or knowingly access Medicaid Fee-For Service programs for any services for individuals meeting the eligibility criteria for Medicaid in these facilities except as permitted under the Medicaid State Inpatient Psychiatric Program Waiver.

7. The Provider shall assist eligible persons' served in preparing and submitting a Medicaid application, including assistance with medical documentation required in the disability determination process.

8. The Provider agrees to assist Medicaid covered eligible person's served of a Medicaid capitated entity in obtaining covered mental health services it determines medically necessary. This assistance shall include assisting clients in appealing a denial of services.

E. Payments from Medicaid Managed Medical Assistance (MMA) Programs, or Provider Services Networks

Unless waived in this Contract, the Provider agrees payments from a health maintenance organization ("HMO"); or provider services network will be considered third party payer contractual fees as defined in Rule 65E-14.001(2)(z), F.A.C. Services which are covered by the sub-capitated contracts and provided to persons covered by these contracts shall not be billed to the ME.

F. Temporary Assistance to Needy Families ("TANF")

1. The Provider's attention is directed to its obligations under applicable parts of Part A or Title IV of the Social Security Act and the Provider agrees TANF funds shall be expended for TANF participants as outlined in the Temporary Assistance to Needy Families (TANF) Guidelines. TANF Guidelines can be obtained from the ME, or can be found at the following web site:

   http://www.myflfamilies.com/service-programs/access-florida-food-medical-assistance-cash/temporary-assistance-needy-families-tanf-maintenance-effort-moe-resources

2. The Contract shall specify the unit cost rate for each covered service contracted for TANF funding, which shall be the same rate as for non-TANF funding, but the Contract shall not specify the number of TANF units or the amount of TANF funding for individual covered services.

3. Provider's that receive TANF funds shall complete the TANF Program Participant Log, and maintain on file, as supporting documentation for the applicable invoice.

G. Invoice Requirements

1. The rates negotiated with the Provider Network will be used to reimburse for services.

2. The Provider is required to comply with Rule 65E-14.021, F.A.C., Schedule of Covered Services, including but not limited to: covered services; unit measurements;

descriptions; program areas; data elements; maximum unit cost rates; required fiscal reports; program description; setting unit cost rates; payment for services including allowable and unallowable units; and requests for payments.

3. The Provider shall request monthly reimbursement for services rendered via the completion of the Invoice for Services as required in this Contract and as specified in Required Reports exhibit.

4. If no services are due to be invoiced from the preceding month, the Provider shall submit written document to the ME indicating this information within seven (7) days following the end of the month. If the Provider fails to submit written documentation of no reimbursement due, within thirty (30) calendar days following the end of the month, then ME may reallocate funds. If the Provider fails to submit written documentation of no reimbursement due for two (2) consecutive months within a twelve (12) month period, ME may exercise its termination clause.

5. The Provider's final invoice must reconcile actual service units provided during the Contract with the amount paid by ME. The Provider shall submit its fiscal year final invoice to ME as specified in Required Reports exhibit.

6. Pursuant to Rule 65E-14.021(10)(b)6.b., F.A.C., worksheet shall not exceed the total number of units reported and accepted in the ME data system pursuant to Rule 65E-14.022, F.A.C.

7. Pursuant to Rule 65E-14.021(10)(a)2., F.A.C., any costs or service units paid pursuant to another contract, or another source are not eligible for payment under this Contract. The Provider must subtract all units which are billable to Medicaid, and all units for client services paid from other sources, including Social Security, Medicare payments, and funds eligible for local matching which include patient fees from first, second, and third-party payers, from each monthly invoice.

H. Supporting Documentation

1. The Provider agrees to maintain and submit to the ME, service documentation for each service billed or subtracted to the ME. The Provider shall track all units billed to the ME by program and by Other Cost Accumulator (OCA). Proper service documentation for each covered service is outlined in Rule 65E-14.021, and F.A.C., regarding “Covered Service Description-Substance Abuse Recovery Support Services (Individual and Group)”; “Covered Service Description-Evidence-Based Practices”; and “TANF SAMH Guidelines and TANF SAMH Incidental Expenditures for Housing Assistance”, as applicable.

2. The Provider shall ensure all services provided are entered into the ME identified data system and PBPS for Prevention Services.

I. Financial Responsibility Policy

BBHC has developed the Subcontractor Financial Responsibility Policy to set up processes that will ensure subcontractor compliance with contractually required data and records submission. The purpose of the Subcontractor Financial Responsibility Policy is to ensure subcontractor compliance with contractual requirements regarding data and

records submission.

Providers that do not submit all required records for enrollment service and discharge, for all funding sources may incur a financial penalty that may reduce their monthly invoice cap (prorated share) by funding pool (OCAs) until the items are corrected and/or submitted, as required. Failure to comply with any provisions of this policy will result in subcontractor non-compliance of their contract and could result in termination of subcontractor's contract.

A. Penalties Due to Missing Discharge Records

The percentage of missing admissions, outcome measures and discharges will be calculated for all contracted providers. Exceptions greater than 3% may be considered for financial penalty.

Providers with exception rates, by program, that are greater than 3% may be placed on a 30-day correction action. Failure to comply with the corrective action will result in a reduction to the providers' monthly invoice cap (prorated share) by their exception rate, up to a maximum reduction of 10% of the amount invoiced. Should the provider make corrections to the extent that they fall on or below the 3% threshold, no penalty shall be taken.

B. Penalties Due to Incorrect Data

Providers must upload data to the Provider Portal by the due dates. Once the data is uploaded it will be reviewed by Carisk and if there are any data entry errors in excess of 3%, the providers will be notified.

Providers must correct the errors within 3-4 days, or as requested. If providers are non-responsive and the data is not corrected there will be a financial penalty of 3%, the following month.

If a provider continues to have the same data error for three (3) consecutive months, then there will be a financial penalty of up to 6% and the provider will be placed on corrective action.

C. Maximum Combined Penalty Reduction

The maximum combined penalty reduction in the monthly-prorated share for providers not compliant with the above categories will not exceed 10% of the entire contract prorated share.

Penalties will be recalculated every month; therefore, once items are corrected, corresponding penalties are removed, and the providers will be able to invoice all the unpaid units up to the prorated share in the subsequent monthly invoice.

D. Adjustment Completion Deadline

All adjustments must be completed before the end of the fiscal year. Any fund balance, based on invoice and data, not being corrected will result in the provider lapsing funds

for the fiscal year.

J. Funding Sweeps

The Provider agrees a review of the funding utilization rate or pattern of the Provider may be conducted by the ME. Based upon such review, if it is determined the rate of utilization may result in a lapse of funds, the ME may amend the Provider's Contract to prevent the lapse of funds. Furthermore, the Provider's Contract may be amended by the ME in order to meet the changing needs of the system of care. The ME will notify the Provider in writing of the need for an amendment prior to increases or decreases to the Contract amount.

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VIII. Required Reports

Required Reports	Due Date	#of Copies	Send to
PAM155-2 Monthly Service Data	Seventh (7) calendar day of the following month for which services were rendered	NA	Carisk Portal / PBPS
Invoice and Supporting documentation	10th calendar day of the following month for which services were provided	1	BBHC Provider SharePoint - Invoices
Incidental Log (As applicable)	10th calendar day of the following month for which services were provided	1	BBHC Provider SharePoint - Invoices
Outreach/Prevention/ TANF Services Log	As Requested	1	BBHC Provider SharePoint - Invoices
Incident Reports	As required in QI001BBHC.0013 Incident Reporting Policy	1	IRAS and incidentreporting@bbhcflorida.org
Financial Statements (Balance Sheet and Statement of Activity)	Quarterly on October 7; January 7; April 7; July 7	1	BBHC Provider SharePoint
Voter Registration Report (As applicable)	Seventh (7) calendar day of the following month for which services were rendered	1	Carisk Partners
Consumer Satisfaction Survey (As Applicable)	Quarterly on September 30; December 31; March 31; June 30	1	DCF Website
Transitional Voucher Report (Quarterly)	Quarterly on the 10th of the month following end of each quarter	1	Care Coordination Manager - Adult
Care Coordination – Child Welfare Census	10th calendar day of the following month for which services were provided	1	Care Coordination Manager - Child Welfare
Family Intensive Treatment (FIT) Team Report	10th calendar day of the following month for which services were provided	1	Care Coordination Manager - Child Welfare

Required Reports	Due Date	#of Copies	Send to
Family Support Teams	10th calendar day of the following month for which services were provided	1	Director of Children's Crisis Services
Family Engagement Program	5th calendar day for the following month for which services were provided	1	Director of Children's Crisis Services
Children Care Coordination	5th calendar day for the following month for which services were provided	1	Director of Children's Crisis Services
Care Coordination Monthly Report and Care Coordination Monthly Census	10th calendar day of the following month for which services were provided	1	Care Coordination Manager - Adult
Clubhouse - Employment Report	10th calendar day of the following month for which services were provided	1	Supportive Employment/ Education Coordinator
Short-term Residential Treatment (SRT)	10th calendar day of the following month for which services were provided	1	Director of Forensic & Criminal Justice Services
Year-End Financial Reports for Providers Not Requiring Audits Per Monitoring and Audits Section			
Schedule of State Earnings	45 calendar days after the end of the Provider's fiscal year.	1	BBHC Provider SharePoint
Schedule of Related Party Transaction Adjustments	45 calendar days after the end of the Provider's fiscal year.	1	BBHC Provider SharePoint
Projected Covered Service Operating and Capital Budget Actual Expenses &Revenues Schedule	45 calendar days after the end of the Provider's fiscal year.	1	BBHC Provider SharePoint
Schedule of Bed-Day Availability Payments	45 calendar days after the end of the Provider's fiscal year.	1	BBHC Provider SharePoint
Agency Prepared Financial Statements (Balance Sheet and Statement of Activity)	45 calendar days after the end of the Provider's fiscal year.	1	BBHC Provider SharePoint

Year-End Financial Reports for Providers Requiring Audits Per Monitoring and Audits Section			
Financial & Compliance Audit to include the necessary schedules per **Monitoring and Audits Section** Including: 1. Schedule of State Earnings 2. Schedule of Related Party Transaction Adjustments 3. Projected Covered Service Operating and Capital Budget (Actual Expenses &Revenues Schedule) 4. Schedule of Bed-Day Availability Payments 5. Agency Prepared Financial Statements (Balance Sheet and Statement of Activity)	170 calendar days after the end of the Provider's fiscal year or 30 calendar days after its completion, whichever comes first. (See **Monitoring and Audits Section)**	1	BBHC Provider SharePoint
Substance Abuse Providers			
Annual Report for HIV Early Intervention Services (SAPT Block Grant Set Aside Funded Services Only)	Upon Request	1	As Requested
Annual Report for Pregnant Women and Women with Dependent Children (SAPT Block Grant Set Aside Funded Services Only)	Upon Request	1	As Requested
Narrative Block Grant Report – as requested – once a year			
Miscellaneous			
Return on Investment Report	Quarterly on the 10th of the month following end of each quarter	1	Managing Director of Operations
Florida Assertive Community Treatment (FACT) Quarterly Report	Quarterly on the 10th of the month following end of each quarter	1	Care Coordination Manager Adult Multidisciplinary Teams
Florida Assertive Community Treatment (FACT) 1. Census 2. Outcomes Report 3. Vacancies	10th calendar day of the following month for which services were provided	1	Care Coordination Manager Adult Multidisciplinary Teams

Required Reports	Due Date	#of Copies	Send to
PBPS Data Entry Training Report for Prevention Program Coordinator and any data entry staff, if applicable (Prevention Service Providers)	Upon Request	1	BBHC Provider SharePoint- Miscellaneous
Prevention Services Invoices Back-Up Report printed from PBPS (Prevention Services Providers)	7th calendar day of the following month for which services were rendered	1	BBHC Provider SharePoint Miscellaneous
Coalition Activities Report (Prevention Services Providers)	Quarterly on October 7; January 7; April 7; July 7	1	BBHC Provider SharePoint Miscellaneous
CAT Team Monthly Reporting Template and CAT Team Waiting List	10th calendar day for the following month for which services were provided	1	Director of Prevention & Intervention
Early Treatment Team	5th calendar day for the following month for which services were provided	1	Director of Prevention & Intervention
Final Invoice	By July 10 of each fiscal year	1	Carisk Apps Portal
Civil Rights Compliance Questionnaire	June 30	1	BBHC Provider SharePoint- Reports
Tangible Property Inventory Report (As applicable)	April 15	1	BBHC Provider SharePoint- Miscellaneous
TANF SAMH Program Logs and Service Data (As applicable)	Upon Request	1	BBHC Provider SharePoint – Invoice Support Documentation

ADA Client Communication Assessment Auxiliary Aid Service Record Monthly Summary Report (As applicable)	By the 5th calendar day following the reporting month	1	BBHC Provider SharePoint – Reports
External Quality Assurance Reviews, Monitoring Reports, Surveys & Corrective Action Plans	As specified in the Paragraph entitled "Inspections and Corrective Action" of the Contract	1	As Requested
Payer Class Data	7th calendar day for the following month for which services were rendered	1	BBHC Provider SharePoint – Invoice Support Documentation
PATH Reports	Quarterly on the 10th of the month following end of each quarter	1	Director of Housing & SOAR Entitlements
PATH Annual Reports (As applicable)	Drafts to be submitted to ME for Southern Region's SAMH Program Office	1	Director of Housing & SOAR Entitlements
TaskForce Fore Ending Homelessness	5th calendar day for the following month for which services were provided	1	Director of Housing & SOAR Entitlements
Mental Health ALF Report (As applicable)	Quarterly on October 15; January 15; April 15; and July 15	1	BBHC Provider SharePoint – Reports
Waitlist - Length of Stay by Level of Care	10th calendar day for the following month for which services were provided	1	Director of Utilization Management
Hospital Bridge Report	10th calendar day for the following month for which services were provided	1	MAT Coordinator
Recovery Community Organization (RCO) Report	10th calendar day for the following month for which services were provided	1	MAT Coordinator
Mobile Response Team Report	10th calendar day for the following month for which services were provided	1	Senior Director of Children System of Care

Behavioral Health Consultant Report	5th calendar day for the following month for which services were provided	1	Child Welfare Integration Manager
Progress Exchange Reports	5th calendar day for the following month for which services were provided	1	Child Welfare Integration Manager
Forensic Services			
Forensic Reports	5th calendar day for the following month for which services were provided		Director of Forensic & Criminal Justice Services
Post Arrest Diversion Report	5th calendar day for the following month for which services were provided	1	Director of Forensic & Criminal Justice Services
Conditional Release Report (As applicable)	5th calendar day for the following month for which services were provided	1	Director of Forensic & Criminal Justice Services
Forensic Residential Treatment Facility Census & Waitlist	10th calendar day of the following month for which services were provided	1	Director of Forensic & Criminal Justice Services

IX. Minimum Service Requirements

For form, refer to BBHC Website: http://www.bbhcflorida.org/

The Provider and its subcontractors shall be knowledgeable of and fully comply with all applicable state and federal laws, rules and regulations, as amended from time to time, that affect the subject areas of the Contract. Authorities include, but are not limited to, the following:

A. PROGRAMMATIC AUTHORITY (FEDERAL)

1. Mental Health

   42 U.S.C. 300x to 300x-9 *(Block Grant for community Mental Health Services)*
   https://www.law.cornell.edu/uscode/text/42/chapter-6A/subchapter-XVII/part-B+

2. Substance Abuse Prevention and Treatment Block Grant (SAPT)

   42 U.S.C. 290kk, et seq.*(Limitation on use of funds for certain purposes)*
   https://www.law.cornell.edu/uscode/text/42/290kk

   42 U.S.C. 300x-21 to 300x-35 and 300x-51 to 300x-66*(SA Treatment & Prevention Block Grants)* https://www.law.cornell.edu/uscode/text/42/chapter-6A/subchapter-XVII/part-B

   42 CFR, Part 54 *(Charitable choice)*
   https://www.ecfr.gov/current/title-42/chapter-I/subchapter-D/part-54

   45 CFR 96.120 – 137 *(SA Treatment & Prevention Block Grants)*
   https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-A/part-96/subpart-L/section-96.120

   Restrictions on expenditures of SAPT

   45 CFR 96.135
   https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-A/part-96/subpart-L/section-96.135

3. Substance Abuse-Confidentiality

   42 CFR, Part 2
   https://www.ecfr.gov/current/title-42/chapter-I/subchapter-A/part-2

4. Health Insurance Portability and Accountability Act (HIPAA)

   45 CFR 164
   https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-C/part-164

5. Social Security Income for the Aged, Blind and Disabled

   20 CFR 416
   https://www.ecfr.gov/current/title-20/chapter-III/part-416

6. Endorsement and Payment of Checks Drawn on the United States Treasury

31 CFR 240 relating to SSA
https://www.ecfr.gov/current/title-31/subtitle-B/chapter-II/subchapter-A/part-240

7. Temporary Assistance to Needy Families (TANF)

   Part A, Title IV of the Social Security Act

   45 CFR, Part 260
   https://www.ecfr.gov/current/title-45/subtitle-B/chapter-II/part-260http://www.access.gpo.gov/nara/cfr/waisidx_03/45cfr260_03.html

   Section 414.1585, F.S.
   http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0400-0499/0414/Sections/0414.1585.html

8. Positive Alternatives to Homelessness (PATH)

   Public Health Services Act, Title V, Part C, Section 521, as amended
   42 U.S.C. 290cc-21 et. seq.
   https://www.law.cornell.edu/uscode/text/42/chapter-6A
   Stewart B. McKinney Homeless Assistance Amendments Act of 1990, Public Law 101-645 https://www.congress.gov/bill/101st-congress/house-bill/3789

   42 CFR, Part 54
   https://www.law.cornell.edu/cfr/text/42/part-54

9. Americans with Disabilities Act of 1990

   42 U.S.C. 12101 et seq.
   https://www.law.cornell.edu/uscode/text/42/12101

B. FLORIDA STATUTES

All State of Florida Statutes can be found at the following website:
http://www.leg.state.fl.us/statutes/index.cfm?Mode=ViewStatutes&Submenu=1

1. Child Welfare and Community Based Care

Chapter 39, F.S.	Proceedings Relating to Children
Chapter 119, F.S.	Public Records
Chapter 402, F.S.	Health and Human Services; Miscellaneous Provisions
Chapter 435, F.S.	Employment Screening
Chapter 490, F.S.	Psychological Services
Chapter 491, F.S.	Clinical, Counseling and Psychotherapy services
Chapter 1002, F.S.	Student and Parental Rights and Educational Choices
Section 402.3057, F.S.	Persons not required to be re-fingerprinted or rescreened
Section 414.295, F.S.	Temporary Cash Assistance; Public Records Exemptions

2. Substance Abuse and Mental Health Services

Chapter 381, F.S.	Public Health General Provisions
Chapter 386, F.S.	Particular Conditions Affecting Public Health
Chapter 395, F.S.	Hospital Licensing and Regulation
Chapter 394, F.S.	Mental Health
Chapter 397, F.S.	Substance Abuse Services
Chapter 400, F.S.	Nursing Home and Related Health Care Facilities
Chapter 435, F.S.	Employment Screening
Chapter 458, F.S.	Medical Practice
Chapter 459, F.S.	Osteopathic Medicine
Chapter 464, F.S.	Nursing
Chapter 465, F.S.	Pharmacy
Chapter 490, F.S.	Psychological Services
Chapter 491, F.S.	Clinical, Counseling and Psychotherapy Services
Chapter 499, F.S.	Drug, Cosmetic and Household Products
Chapter 553, F.S.	Building Construction Standards
Chapter 893, F.S.	Drug Abuse Prevention and Control
Section 409.906(8), F.S.	Optional Medicaid – Community Mental Health Services

3. Developmental Disabilities

Chapter 393, F.S.	Developmental Disabilities

4. Adult Protective Services

Chapter 415, F.S.	Adult Protective Services

5. Forensics

Chapter, F.S.916, F.S.	Mentally Deficient and Mentally Ill Defendants.
Chapter 985, F.S.	Juvenile Justice; Interstate Compact on Juveniles
Section 985.19, F.S.	Incompetency in Juvenile Delinquency Cases
Section 985.24, F.S.	Interstate Compact on Juveniles; Use of detention; Prohibitions

6. Florida Assertive Community Treatment (FACT)

General Appropriations Act
https://www.flsenate.gov/Session/Appropriations/2018

7. State Administrative Procedures and Services

Chapter 120, F.S.	Administrative Procedures Act
Chapter 287, F.S.	Procurement of Personal Property and Services
Chapter 815, F.S.	Computer - Related Crimes
Section 112.061, F.S.	Per diem and Travel Expenses*
Section 112.3185, F.S.	Additional Standards for State Agency Employees
Section 215.422, F.S.	Payments, Warrants & Invoices; Processing Times

Section 216.181(16)(b), F.S.	Advanced funds invested in interest bearing accounts

***Travel Expenses are specified in the DFS Reference Guide for State Expenditures**
https://www.ecfr.gov/current/title-2/subtitle-A/chapter-II/part-200/subpart-E/subject-group-ECFRed1f39f9b3d4e72/section-200.475

C. FLORIDA ADMINISTRATIVE CODE (RULES)

1. Child Welfare and Community Based Care

   All references to F.A.C. may be found at the following website:
   https://www.flrules.org/default.asp

Rule 65C-12, F.A.C.	Emergency Shelter Care
Rule 65C-13, F.A.C.	Substitute Care of Children
Rule 65C-14, F.A.C.	Group Care
Rule 65C-15, F.A.C.	Child Placing Agencies

2. Substance Abuse and Mental Health Services

Rule 65C-12, F.A.C.	Emergency Shelter Care
Rule 65D-30, F.A.C.	Substance Abuse Services Office
Rule 65E-4, F.A.C.	Community Mental Health Regulation
Rule 65E-5, F.A.C.	Mental Health Act Regulation
Rule 65E-10, F.A.C.	Psychotic and Emotionally Disturbed Children Purchase of Residential Services Rules
Rule 65E-12, F.A.C.	Public Mental Health, Crisis Stabilization Units, Short Term Residential Treatment Programs
Rule 65E-14, F.A.C.	Community Substance Abuse and Mental Health Services- Financial Rules
Rule 65E-15, F.A.C.	Continuity of Care Case Management
Rule 65E-20, F.A.C.	Forensic Client Services Act Regulation

3. Financial Penalties

Rule 65-29, F.A.C.	Penalties on Service Providers

4. Reduction/ Withholding of Funds

Rule 65-29.001, F.A.C.	Financial Penalties for a Provider's Failure to Comply with a Requirement for Corrective Action

D. MISCELLANEOUS

1. Department of Children and Families Operating Procedures

CFOP 155-10, Services for Children with Mental Health & Any Co-occurring Substance Abuse
Treatment Needs In Out of Home Care Placements
https://www.myflfamilies.com/admin/publications/cfops/CFOP%20155-xx%20Mental%20Health%20-%20Substance%20Abuse/CFOP%20155-01,%20Guidelines%20for%20the%20Use%20of%20Psychotherapeutic%20Medications%20in%20State%20Mental%20Health%20Treatment%20Facilities.pdf

CFOP 215-6, Incident Reporting and Client Risk Prevention
https://www.myflfamilies.com/admin/publications/cfops/CFOP%20215-xx%20Safety/CFOP%20215-6,%20Incident%20Reporting%20and%20Analysis%20System%20(IRAS).pdf

2. Federal Cost Principles

   Uniform Grant Guidance
   http://www.ecfr.gov/cgi-bin/text-idx?SID=6214841a79953f26c5c230d72d6b70a1&tpl=/ecfrbrowse/Title02/2cfr200_main_02.tpl

   OMB Circular A-21, Cost Principles for Educational Institutions https://georgewbush-whitehouse.archives.gov/omb/circulars/a021/fedrega21.html

   OMB Circular A-87, Cost Principles for State, Local and Indian Tribal Governments https://obamawhitehouse.archives.gov/omb/circulars_a087_2004/

   OMB Circular A102, Grants and Cooperative Agreements with State and Local Governments https://georgewbush-whitehouse.archives.gov/omb/circulars/a102/a102.html
   OMB Circular A-122, Cost Principles for Non-profit Organizations https://georgewbush-whitehouse.archives.gov/omb/circulars/a122/a122.html

3. Audits

   Uniform Grant Guidance
   http://www.ecfr.gov/cgi-bin/text-idx?SID=6214841a79953f26c5c230d72d6b70a1&tpl=/ecfrbrowse/Title02/2cfr200_main_02.tpl

   OMB Circular A-133, Audits of States, Local Governments and Non-Profit Organizations https://georgewbush-whitehouse.archives.gov/omb/circulars/a133/a133.html

   Section 215.97, F.S., Florida Single Audit Act
   https://apps.fldfs.com/fsaa/statutes.aspx
   Comptrollers Memorandum #03 (1999-2000): Florida Single Audit Act Implementation https://apps.fldfs.com/fsaa/

4. Administrative Requirements

45 CFR Part 75 - Uniform Administrative Requirements, Cost Principles, And Audit Requirements for HHS Awards https://www.govinfo.gov/app/details/CFR-2016-title45-vol1/CFR-2016-title45-vol1-part75

45 CFR, Part 92 - Uniform Administration Requirements https://www.govinfo.gov/content/pkg/CFR-2011-title45-vol1/pdf/CFR-2011-title45-vol1-part92.pdf

OMB Circular A110, Uniform Administrative Requirements for Grants and Other Agreements https://georgewbush-whitehouse.archives.gov/omb/circulars/a110/a110.html

5. Data Collection and Reporting Requirements

Rule 65E-14.022, F.A.C.
https://www.flrules.org/gateway/ruleNo.asp?ID=65E-14.022

Section 397.321(3)(c), F.S., Data collection & dissemination system
http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL= 0300-0399/0397/Sections/0397.321.html

Section 394.74(3)(e), F.S., Data Submission
http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL= 0300-0399/0394/Sections/0394.74.html

Section 394.77, F.S., Uniform management information, accounting, and reporting systems for providers.
http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL= 0300-0399/0394/Sections/0394.77.html

CFP 155-2, Mental Health and Substance Abuse Data Measurement Handbook
http://www.dcf.state.fl.us/programs/samh/pubs_reports.shtml

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X. PATH Broward

The Projects for Assistance in Transition from Homelessness (PATH) is funded by a formula grant authorized by the Stewart B. McKinney Homeless Assistance Amendments Act of 1990. PATH grants are distributed annually by SAMHSA to all 50 states, the District of Columbia, Puerto Rico, the Northern Mariana Islands, Guam, American Samoa, and the U.S. Virgin Islands. PATH, the first major federal legislative response to homelessness, is administered by and funded through the Center for Mental Health Services (CMHS), a division of SAMHSA, within the U.S. Department of Health and Human Services (HHS). BBHC PATH programs will be in alignment with the DCF Guidance 15 - Projects for Assistance to Transition from Homelessness (PATH).

States and territories are referred to as PATH grantees. The Department of Children and Families SAMH Program Office is the PATH grantee for Florida, who works with the MEs to oversee the programs, Local Intended Use Plans (LIUP) and annual budgets.

The goal of the PATH program is to reduce or eliminate homelessness for individuals with serious mental illnesses or co-occurring serious mental illness and substance use disorders, who are experiencing homelessness or are at imminent risk of becoming homeless. PATH funds are used to provide an array of allowable services, including street outreach, case management, and services that are not supported by mainstream mental health programs.

PATH Providers:
The minimum responsibilities and expectations of PATH providers are listed below.

1. PATH providers are expected to integrate SAMHSA's definition and principles of recovery into their programs to the greatest extent possible.

2. PATH providers are expected to integrate positive programmatic involvement of individuals with mental health issues and their family members when possible into the program design. This reconnection should be facilitated meaningfully and span all aspects of the organization's activities as described below.

3. It is crucial for PATH providers to establish relationships with the local CoC, Housing Authorities, landlords, faith-based organizations, and other agencies/organizations providing services and supports to individuals who are experiencing homelessness.

4. PATH providers should ensure that individuals enrolled in PATH are transitioned to mainstream services, with the understanding that these services will remain available to the consumer after their transition out of homelessness. The PATH program encourages a focus on sustainable mental health services and housing. Other mainstream services of importance are services that provide health care, employment/vocational training, community connection, support, and resources for daily needs.

5. Establish a service plan for all PATH-enrolled individuals including:
    a. Goals to obtain community mental health services for the individual;
    b. Coordinating and obtaining needed services for the individual, including services relating to shelter, daily living activities, personal and benefits planning, transportation, habilitation and rehabilitation services, prevocational and employment services, and permanent housing;

c. Assistance to obtain income and income support services, including housing assistance, Supplemental Nutrition Assistance Program (SNAP) benefits, and Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI);
d. Referrals to other appropriate services; and
e. Review of the plan not less than once every three months.

6. Maintain individual client files containing an intake form, a determination of eligibility for PATH-funded services, a service plan, and progress notes for each person served with PATH funds.

7. Maintain individual client files containing an intake form, a determination of eligibility for PATH-funded services, a service plan, and progress notes for each person served with PATH funds.

8. PATH providers are responsible for prioritizing PATH services to veterans and individuals experiencing chronic homelessness who meet PATH eligibility.

9. PATH outreach requires multiple contacts to build a trusting relationship and engage individuals eligible for PATH services. After becoming enrolled in PATH, continued contacts with the individual are needed to assist the individuals in meeting basic needs, medical care, benefits, housing, and mental health treatment and supports. Most of the staff work time is spent working directly with the individual. Work hours should be flexible and not necessarily 8:00 a.m. to 5:00 p.m. Staff should flex work hours to work early mornings, early evenings, and weekends because individuals who are experiencing homelessness may be more visible during these times, especially in camps or street locations.

10. PATH providers should hold team meetings frequently, even as often as weekly, to ensure good communication among team members. It is recommended that the team members work together and share caseloads so more than one staff member is familiar with the consumers and could provide SAMHSA's Homeless and Housing Resource Network PATH services. For example, it is crucial to take action as soon as individuals enrolled in PATH make the commitment to participate in mental health treatment because this opportunity may not last. If the primary staff member is not available, another staff member would need to assist the individual. Team meetings are also important for discussing challenges that staff may have during outreach or while engaging and providing services to individuals experiencing homelessness and serious mental illness.

11. PATH staff members work with the most vulnerable individuals in our communities. These are individuals who have active symptoms of mental illness and with whom it may be difficult to engage. It is crucial for staff to be supported in the work they do, to be offered opportunities for growth, and to feel satisfied with the work they are doing. Staff supervision is important to advancing these goals. Supervisors are responsible for providing the support necessary to identify instances of "burnout," identify the need for additional training to improve skills, and to assist staff with alternative methods for providing service to those individuals that may be a challenge to work with. Supervision should be scheduled as often as the individual staff member deems necessary.

12. PATH providers must ensure that PATH staff members receive the training necessary to perform the highest quality of work. It is recommended that all staff receive training in the following areas:

a. Outreach and engagement
b. Motivational interviewing
c. Trauma-informed care (TIC)
d. Cultural and linguistic competency
e. Recovery
f. Person-centered thinking
g. Crisis response and suicide prevention (e.g., applied suicide intervention skills training)
h. Housing First
i. Critical Time Intervention (CTI)

Additionally, PATH providers must maintain program data and complete the annual report. The ME will work with DCF annually to compile and review the Local Intended Use Plan (LIUP) and budget. Providers must:

- Enter quarterly summary information about PATH programs and services into the PATH Data Exchange (PDX) at https://pathpdx.samhsa.gov no later than the 10th of the month following the quarter of services.
- Submit an annual report into PATH Data Exchange no later than November 17th via the PATH Data Exchange (PDX) at https://www.pathpdx.org/.

Quarterly Report	PATH FY	Reporting Start Date	Reporting End Date	Due to SAMH (via PDX)
Progress 2022 – 1	FY 22-23	July 1, 2022	September 30, 2022	October 10th
Progress 2022 – 2	FY 22-23	July 1, 2022	December 31, 2022	January 10th
Progress 2022 – 3	FY 22-23	July 1, 2022	March 31, 2023	April 10th
Progress 2022 – 4	FY 22-23	July 1, 2022	June 30, 2023	July 10th

- Enter SSI/SSDI application data into SOAR Online Application Tracking (OAT) database at soartrack.prainc.com/, in accordance with Managing Entity Contract Guidance 9.
- Implement individual SOAR training to case managers and agency leads using the SOAR Online Course, available at: https://soarworks.prainc.com/course/ssissdi-outreach-access-and-recovery-soar-online-training
- Provide at least one dollar of local matching funds for every three dollars of PATH funds received and expend local matching funds to provide eligible services to PATH eligible persons. Match-funded expenditures must align with the services identified in the Local Intended Use Plan. The formula to be followed is cited in Title V, Part C, Section 524 of the Public Health Services Act (42 U.S.C. 290cc-21 et. seq.).

1. Ensure the accuracy of data submitted for the PATH Annual Report.
2. Enter data into the PDX portal for final review by the ME.
3. Ensure timely submission of the PATH Annual Report to the ME.

4. Participate in monitoring at least annually to ensure the minimum program priorities indicated above are provided, PATH funds are expended appropriately, and data is collected and reported for the PATH Annual Report.
5. Participate in any local, state or national calls, trainings or learning collaborative.

SOURCE: https://www.pathpdx.org/UserFiles/PATH%20Program%20Guide%20-%20FINAL.pdf

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XI. Statewide Inpatient Psychiatric Programs (SIPP) Services

Statewide Inpatient Psychiatric Program (SIPP) services are to provide extended psychiatric residential treatment with the goal of facilitating successful return to treatment in a community-based setting. SIPP services include:

- Individual plan of care
- Assessment
- Routine medical and dental care
- Certified educational programming
- Recreational, vocational, and behavior analysis service
- Therapeutic home assignment

Services to be Performed. During the term of this Agreement, the Network Provider will maintain licensure as a Residential Treatment Center or Psychiatric Hospital under either Chapters 6 5M-9 or 59A·3 of the Florida Administrative Code and perform SIPP services a s contracted with the Agency for Health Care Administration (AHCA) for non-Medicaid children.

Compensation. For the period of the Agreement, the Network Provider agrees to accept the negotiated daily rate; for the "ME" pre-approved service, based on bed day utilization.

Changes to Level of Service. The Network Provider agrees that any changes to a participant's approved level of service must be authorized by the "ME" before delivery of additional services. Services not previously approved by the "ME" shall not be reimbursable.

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XII. Early Treatment Team Program formerly known as First Episode

See NAVIGATE manuals for more information on program requirements

- The First Episode Psychosis Program follows the NAVIGATE Model.
- The program **teaches young people and their families the skills** and information needed to get back on their feet and work towards a productive, full life.
- The program **involves several different interventions,** including medication management, resiliency training, help getting back to work or school, and a family support/education program to increase the success of recovery.
- These **interventions are effective** in helping people get on with their lives even after they have experienced these kinds of problems.
- Individuals will learn strategies that will help them to **pursue their goals** and get on with their lives.
- Individuals will **learn coping strategies** that will help them better manage their illness and psychotic symptoms.
- Individuals will be **working with a team** to help with their goals. The team includes the following members:
  - Director: Coordinates and leads the team, and provides the Family Education Program
  - Prescriber: Provides individualized medication treatment (e.g., psychiatrist or nurse)
  - Clinicians: Two clinicians who provide Individualized Resiliency Training and case management
  - Supported Employment and Education Specialist: Provides individualized rapid job search and follow-along supports
- Team Meetings: NAVIGATE team meetings occur weekly to develop possible ideas on preliminary treatment plans for new young people, discuss and review progress, and address any issues. The Director leads the team meetings.
- Supervision Meetings: The Director meets with the two clinicians for one hour weekly and meets with the Employment and Education Specialist for one hour a week.
- Collaborative Treatment Planning and Review Meeting: These meetings occur within one month of a young person's enrollment into the NAVIGATE program. A one-hour collaborative meeting occurs with the young person, relatives and significant other (if applicable), the Director, and any other members of the NAVIGATE team who are involved in treatment planning.
  - At least every six months after completing the initial collaborative treatment plan, the team comes together to complete a review.

Collaborative Treatment Planning and Reviews

MEETING	TEAM MEMBERS PRESENT	WHEN
Preparation for Collaborative Treatment Planning Meeting (approx. 20-30 minutes)	All NAVIGATE Team Members	3-4 weeks after a young person begins NAVIGATE, during the weekly team meeting
Collaborative Treatment Planning Meeting (30-60 minutes)	NAVIGATE Director and most relevant team member(s), young person, family members (and other supporters)	One month after a young person begins NAVIGATE
Preparation for Collaborative Review Meeting (20-30 minutes)	All NAVIGATE Team Members	Before Collaborative Review Meeting, during the weekly team meeting
Collaborative Review Meeting (30-60 minutes)	NAVIGATE Director and most relevant team member(s), young person, family members (and other supporters)	Every six months after the development of the initial treatment plan

The NAVIGATE Model

TREATMENT	PROVIDER	AIMS
Medication Management	Psychiatrist, Nurse	• Monitor the use of medication to reduce symptom distress • Prevent relapses to help achieve desired goals
Family Education	Program Director	• Teach families about psychosis • Provide skills to help families move forward in recovery • Reduce family stress through improved communication and problem-solving skills • Educate natural supports on ways to assist young people in illness management and obtaining goals
Individual Resiliency Training	Individual Resiliency Trainer (IRT) Clinician	• Teach about psychosis and processing the experience • Help young people achieve their personal goals by teaching about their disorder and its treatment • Reduce self-stigmatizing beliefs • Help young people learn social and resiliency skills

Supported Employment/Education	Trained Employment/ Education Specialist (SEE)	• Provide individual employment services to young people with a desire to work • Find competitive employment in community settings (not sheltered or transitional work) with a rapid job search (rather than long vocational assessments or prevocational training) • Provide support based on the preferences of young people (e.g., type of job, decision to disclose mental health challenges to an employer) • Follow-along support for those employed or in school

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XIII. Family Engagement Program (FEP)

I) Philosophy of the Program:

- The goal of the Family Engagement Program (FEP) is to link caregivers/parents to a SUD evaluation/assessment within 48 business hours of referral when there is an open Child Protection Case, and to share the assessment findings and recommendations with CPI and enter into FSFN promptly. Services are provided by a team of peer advocates (5) all in recovery and who bring experience with the child welfare system and provide outreach and assertive linkage to needed resources in order to lessen the likelihood of child abuse and neglect and reduce the potential for further child dependency actions, by motivating the family to follow the clinically recommended services. The program adheres to system of care values which include but are not limited to: Strength based; Collaborative and Integrated; Persistent Commitment; Community based; Culturally Competent; and Outcome Driven.

II) Program Description: (program is being updated to align with state requirements.)

- The FEP team members are co-located with the Department of Children and Families (DCF) Child Protection Investigations Section (CPIS). The team is supervised by a licensed behavioral health professional. The FEP serves families with children (ages 0-10) for whom the child abuse investigation by the CPI or Behavioral Health Consultant (BHC) Brief Assessment, revealed suspected or substantiated substance use that require intervention to prevent occurrence of repeated maltreatment.

- The team leader is available as a support to the DCF Child Protective Investigations Section (CPIS) Office and provides oversight and supervision for the team and is available as a support to the DCF/CPIS unit in staffing challenging cases and ensuring integration and collaboration between the team, DCF and community partners.

- FEP is responsible for establishing a protocol for referral process to be shared with CPIS along with any other prospective referral source and posted on the Center for Child Welfare website. To be developed by Provider and Approved by ME. The revised referral protocol is to be included in the FEP Manual.

- FEP is responsible for maintaining a call center based on a provider block scheduling protocol for referral process to be shared with CPIS and posted on the Center for Child Welfare website. To be developed by Provider and Approved by ME. The revised referral protocol is to be included in the FEP Manual. All referrals are to be thought BBHC Cognito Portal link below. All subsequent referral outcomes are to be tracked in FEP SMARTHSEET database.

  https://www.cognitoforms.com/BrowardBehavioralHealthCoalition/FAMILYENGAGEMENTPROGRAMREFERRAL

- The FEP call center is responsible for receiving calls from the caregiver, CPI and/or BHC to provide a scheduled assessment (to include date, time, and provider location) within 48 business hours of the call, M-F 9:00am—5:00pm. If a FEP call is unable to be completed for any reason, FEP is responsible to follow up within 24 business hours of Cognito referral and provide the caregiver with a scheduled assessment (date, time and

location of provider). All efforts are to be documented in FSFN and shared directly with referral source.

- During the assessment and resulting recommendation process, the FEP Peer Specialist works to engage and motivate the parent/caregiver in understanding the resulting recommendation, how following the resulting recommendation can create positive family changes, and the benefits of engaging in services. The FEP team will also address with the caregiver/family any barriers the caregiver has experienced or is experiencing, with completing the assessment, entering into recommended service. This is including, but not limited to, lack of appropriate engagement efforts needed to motivate the caregiver through the change process, lack of transportation, lack of childcare, etc.

- The team will ensure a “warm hand off” to the selected provider and provide any needed concrete support to ensure a successful link. The team will close cases once the “warm hand off” is completed and the caregiver/family has successfully completed at least two outpatient appointments or two weeks of group and/or residential services. In cases where providers contact FEP after a “warm hand off” is completed and FEP case closure, reporting client disengagement, FEP will make all reasonable efforts to reengage with the family to determine what barriers are being experienced leading to the disengagement, plan to overcome barriers and document all efforts in FSFN.

- The team will utilize flexible funds for concrete support, pro social activities, and to remove barriers associated with the recovery process.

- The team will collaborate with CPI’s to obtain any needed background information on referred families.

- Peer Specialists update CPI’s/BHC’s on a regular basis via email and/or phone contact with all progress made/not made and document such information in FSFN within 48 business hours of action completion. This includes the outcomes of the substance use assessments, the UA results, and the treatment recommendations.

- Peer Specialists also update caregivers/parents on the outcomes of the substance use assessments, UA results, and treatment recommendations via a phone call and/or in person visit to ensure a mutual understanding of the assessment and resulting recommendations understand the recommendations.

- Upon case closure, Peer Specialists notify the CPI’s via email and provide a closing summary. This closing summary, is to uploaded into the file cabinet in FSFN, within 5 business days of closure.

- Provider Management will maintain a data tracking log in SMARTSHEET for all referrals to include the data elements outlined in the SMARTSHEET database.

- FEP will maintain a record of each referral. The record shall contain the referring documents, all drug test results, screenings, signed consents, assessments and any other records that pertain to the family’s episode of care with the Family Engagement Program.

- **All documentation shall be entered into FSFN within 48 hours**. Including but not limited to referral, intake, SUD evaluation, drug test results, and treatment information.

- FEP Provider is responsible for conducting weekly random reviews to ensure documentation in FSFN is completed within 48 hours.

- FEP provider will be responsible for remedial action to be taken to ensure documentation is completed.

Caregivers/Parents referred to FEP will receive engagement and outreach services to encourage participation in the most appropriate treatment services to address the recommendations of the assessment**.**

FEP will accommodate any caregiver and family when services are needed, even if those supports/services fall outside of standard business hours.

Admission Criteria:

1. Youth 10 and under
2. Resident of Broward County
3. Referred by DCF/CPIS

Discharge Criteria/Transition

1. Successfully linked to a substance use treatment provider.
2. If a caregiver declines services at any point while the case is open
3. No longer a resident of Broward County
4. If no contact is made

III) Measurable Program Outcomes and Objectives:

1. FEP provides a scheduled SUD assessment (date, time and provider location) within 48 business hours of referral to FEP.
2. 70 percent of the referrals to FEP from CPIS complete an assessment.
3. Of those 70 percent of completed assessments, 80 percent of individuals who are recommended for treatment, are engaged in treatment at the time of case closure by FEP.
    a) Best efforts are to be made to ensure parents/caregivers are successfully engaged in the appropriate services within 7 days of the assessment.

IV) Mechanisms to address the Needs of Special Populations:

All persons served will be assessed for their individual needs to address abuse/neglect and overall family functioning in their household. Ethnic, cultural, linguistic, and spiritual traditions of the person served are respected and incorporated into service delivery whenever appropriate and applicable. All services meet or exceed the required standards of the Americans with Disabilities Act (ADA) and Title VI of the Civil Rights Act. Staff is also expected to conduct themselves in a manner agreeable to the diverse population served. Any special needs are to be assessed throughout treatment and referrals are to be made as clinically indicated and desired by the person served.

V) Staffing Structure and Resources:

This Program is staffed by one (1) Master level clinician and five (5) Peer Specialists under the supervision of a licensed coordinator. Staff members are housed at DCF CPIS and have access to their conference and interview rooms that ensures confidentiality, if needed. All staff have access to resource guides including the Connections Book, DCF Directory, and

First Call for Help to ensure up to date information on other service providers, advocacy/self-help groups, financial aid, legal aid, housing, and other needed resources. The program will make every attempt to provide access to staff that is culturally and linguistically diverse to reflect the population served as well as provide cultural diversity training.

VI) Procedures to support Interdisciplinary Team Interaction:

Every family entering the program is discussed with a supervisor after completion of the initial contact and referred to the most appropriate interventions. In addition, the FEP staff work closely with the case managers, DCF/CPIS and/or ChildNet professionals and participate in interdisciplinary meetings to ensure continued collaboration. The team maintains on their staff a Licensed Practitioner of the Healing Arts, mental health technicians, parent advocates, and medical staff that are available to all persons served via the internal referral process. Peer Specialist completing the intake will ascertain through the engagement process what other family members, and/or professional supports are involved with the caregiver. With the caregiver's consent and signed releases, peer specialist will attempt to engage and collaborate with any identified supports.

Training Activities for Staff Competency

All staff members attend a three-day Orientation upon hire regarding agency policies / procedures and agency required trainings. In addition, assessors receive ongoing trainings on principals of abuse/neglect, WRAP training, WRAP facilitator training as available and the entire team will have training in Motivational Interviewing. The team shall also receive training in Trauma Informed Care and Mental Health First Aid training, as available. In addition, therapists receive weekly supervision by their supervisor who has extensive experience with the population served. Staff members are also able to attend internal and external trainings on topics related to their job at the supervisor's discretion.

All Peer Advocates on the team are to have personal lived experience in recovery from substance use. BBHC funds the Peer Certification training through South Florida Wellness Network. All Peers on the team are to receive the training, work experience hours, and certification (CRPS-A) through the Florida Certification Board within 18 months of hire. Ongoing CEU's are required on a yearly basis to maintain certification.

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XIV. Family Support Team

PURPOSE AND GOALS

Family Support Teams serve to assist children and their families in the process of stabilizing the youth and home environment until they are effectively connected with services and supports needed. The Family Support Teams will ensure that the children are effectively connected with the services and support they need in order to continue their progress towards community-based care. It will also assist the families of these youth to support and guide them through the process. This includes services and supports that affect both the children and families' well-being, such as primary physical health care, behavioral health, housing, and social connectedness. It is time-limited, with a heavy concentration on stabilizing, educating, and empowering the youth and family served as well as providing a single point of contact until the persons served are adequately connected to the care that meets their needs. Family Support Teams work towards connecting all systems involved including behavioral health, primary care, peer and natural supports, housing, education, vocation, and the justice systems to ensure continuity of care.

The short-term goals of Family Support Teams are to:

1. Ensure that any youth/support system needing services does not experience gap in services.
2. Stabilizing youth and their home environment until recommended higher level of care is available or until youth and their home environment are stable enough to transition to a lower level of care.
3. Decrease avoidable hospitalizations, inpatient care, incarcerations, and homelessness; and focus on the child and family's wellness and community integration.

The long-term goals of the Family Response Team are to:

1. Shift from an acute care model of care to a recovery model; and
2. Offer an array of services and supports to meet an individual's chosen pathway to recovery.
3. Client and family de-escalation of behaviors.

PRIORITY POPULATIONS

Individuals at a CSU or in the community that require but are not limited to services such as behavioral health, primary care, peer and natural supports, housing, education, and employment.

1. With history or previous CSU/Baker Acts.
2. Who have high utilization of services.
3. With multiple service needs with at least one of the problem areas identified as "severe", pregnant youth, IV drug users, and/or serious mental illness.
4. With a Serious Mental Illness (SMI) awaiting placement in a civil state mental health treatment facility (SMHTF) or awaiting discharge from a SMHTF back to the community.
5. With a SMI and/or substance use disorder (SUD) who account for a disproportionate amount of behavioral health expenditures.
6. With a SMI and/or SUD who have a history of multiple arrests, involuntary placements, or violations of parole leading to institutionalization or incarceration.
7. With involvement in the child welfare system or behavioral health system who are suspected to be involved or are involved in human trafficking.
8. Without a strong support system that can support the child with ongoing services in the community.

9. Who have been identified as needing a higher level of care that is not available at that time**NETWORK SERVICE PROVIDER RESPONSIBILITIES**

Network Service Provider responsibilities include:

1. Engage the individual and their support system in their current settings, community, CCU and SIPPs.
2. Utilize a standardized level of care tool and assessments to identify service needs and choice of the individual served.
3. Serve as single point of accountability for the coordination of a child's care with all involved parties (i.e., juvenile justice, child welfare, primary care, behavioral health care, housing, etc.).
4. Develop a plan with the children and family based on shared decision making that emphasizes individual and home environment stabilization, self-management, recovery, and wellness.
5. Provide frequent contact during the time of services.
6. Coordinate care across systems, to include behavioral and primary health care as well as other services and supports that impact the social determinants of health.
7. For children or support person who require medications, ensure linkage to psychiatric services.
8. Coordinate with the managing entity to identify service gaps and request purchase of needed services not available in the existing system of care.
9. Develop partnerships and agreements with community partners (i.e., managed care organizations, criminal and juvenile justice, community-based care organizations, housing providers, federally qualified health centers, etc.) to leverage resources and share data.
10. Ensure linkage with Managed Care case manager when applicable.

OUTCOMES

- Number of children linked to community programs
- Number of clients enrolled in Medicaid Managed Plans
- Number of children involved with Child Welfare
- Number of children involved with DJJ

Performance Measures

- School, Preschool and Daycare Attendance
- Improved Level of Functioning, based upon CFAR, FARS, or CANS
- Living in a community Setting
- Improved Family Functioning based upon NCFAS – G+R, or CANS

CARE COORDINATION ALLOWABLE COVERED SERVICES

The following is a list of allowable covered services as defined in Ch. 65E-14.021, F.A.C.

1. Intervention

XV. Family Intensive Treatment Team (FITT)

I) Philosophy of the Program:

The Family Intensive Treatment (FITT) team model is designed to provide intensive team-based, family-focused, comprehensive services to families in the child welfare system with parental substance abuse.

The BBHC FITT Teams will abide by the Guidance 18 - Family Intensive Treatment (FIT) Model Guidelines and Requirements.

II) Program Description:

The Family Intensive Treatment Team(s) delivers intensive treatment interventions targeted to families with high-risk child abuse cases, (as defined by the Motivational Support Program Protocols, "*Unsafe*", "*Conditionally Safe*", "*Risk*" or as otherwise defined by the Department of Children and Families), due to parental substance use and/or mental health issues. This program has been designed to demonstrate that rapid identification of parental behavioral health disorders, immediate access to evidence-based practices and multi-disciplinary teaming will result in better outcomes for children and their families. The project provides family-based integrated services. It documents the qualitative and quantitative system components necessary to be responsive to the needs of caregivers/parents with behavioral health disorders and their young children. Services are provided in the home for an average of 6 months and include assessment, multi system care coordination, individual/family therapy, parenting interventions, psychiatric evaluation, medication management, and access to residential and primary health.

III) Admission Criteria:

1. Have a substance use disorder;
2. Have at least one child between the ages of zero (0) and ten (10) years old;
3. Have been referred by a child protective investigator (CPI), dependency case manager, or community-based care (CBC) lead agency;
4. Are either under judicial supervision in dependency court (both in-home and out-of-*home). For out-of-home cases, only those caregivers/parents with goal of reunification, or have been assessed as unsafe; and
5. Are willing to participate in the FITT Program, may be court ordered.

IV) Program Goals:

- Increase immediate access to substance use and co-occurring mental health services for caregivers/parents in the child welfare system;
- Increase children's safety and reduce risks;
- Increase parental protective capacity; and
- Reduce rates of re-abuse and neglect of children with caregivers/parents with a substance use disorder.
- Reduce the number of out of home placements and the time the children remain in the child welfare system,
- Help substance using caregivers/parents overcome addictions and improve involvement in recovery services.

V) Measurable Program Objectives:

1. Accept families referred by the child protective investigator, child welfare case manager, community-based care lead agency and/or the Motivational Support Program (formerly known as Family Intervention Specialists).

2. Initiate contact with the family within 2 business days of the referral. The FIT team Provider shall ensure that initial and reoccurring efforts to contact and engage the referred families are documented.

3. Document the date of enrollment as the date the caregivers/parents signed consent for services.

4. Complete the initial assessments to determine the level of care and severity within 15 business days of enrollment and include the following assessments, at a minimum:
   a. American Society of Addiction Medicine (ASAM) to assess level of care; and
   b. Biopsychosocial Assessment to assess the severity of substance use disorders and other behavioral health needs.

5. Provide treatment services by the clinician within 2 business days of completing the initial assessments (ASAM & Biopsychosocial). The completion of the treatment plan with the family may be the first service.

6. Complete additional assessments within 30 calendar days of enrollment.

7. Each family shall have a comprehensive treatment plan, which is completed no more than 30 days after intake to guide the provision of FIT services. At a minimum, the treatment plan shall:
   a. Be developed with the participation of the family receiving services;
   b. Specify the specific services and supports to be provided;
   c. Specify measurable treatment objectives, goals and target dates for services and supports; and
   d. Be reviewed, revised or updated every three months, or more frequently as needed to address changes in circumstances impacting treatment, with the participation of the parent(s) receiving services.

8. Provide immediate access to substance use disorder treatment within 48 hours of the assessment being completed, if necessary. Telehealth/telemedicine can be used to facilitate service provision.

9. No later than seven 7 business days prior to a family's discharge from services:
   a. Review the family's treatment during a multidisciplinary team meeting to ensure that the family is receiving adequate behavioral health services that addresses the behavioral health condition and promote relapse prevention and recovery;
   b. Complete a Discharge Summary containing:
      1) The reason for the discharge;
      2) A summary of FIT services and supports provided to the family;
      3) A summary of resource linkages or referrals made to other services or supports on behalf of the family; and
      4) A summary of each family member's progress toward each treatment goal in the treatment plan.

10. On a monthly basis, submit the Template 17-FIT Reporting template by the 12th of the month to the Managing Entity.
11. **On a monthly basis, submit a comprehensive update as to the family's progress directly into the Florida Safe Families Network database.**

VI) Discharge Criteria:

Persons may be discharged after they complete treatment goals or are provided with a "warm hand off" to an appropriate service provider. It is anticipated that at discharge 90% of caregivers/parents served will be living in a stable housing environment and that 80% of caregivers/parents served will have improved their level of functioning as measured by the DLA-20. 80% of caregivers/parents that complete the pre and post AAPI-2 shall improve their parenting score from admission to discharge. The FIT team provider will complete 85% of discharge summaries within 7 business days prior to discharge. The FIT team will have 85% of the initial care assessments (ASAM and Biopsychosocial) completed within 15 business days of enrollment.

FIT team providers shall engage all families, who have successfully completed their treatment goals, in aftercare services in an effort to foster continued positive outcomes and protective factors. Aftercare services may consist of, but are not limited to support groups, peer support services, home visits, telephone calls, and case management services. Incidental funds may also be used to assist families with aftercare expenses. Aftercare services may be provided for up to 6 months.

VII) Mechanisms to address the Needs of Special Populations:

All persons served will be assessed for their individual needs to address abuse/neglect and overall family functioning in their household. Ethnic, cultural, linguistic, and spiritual traditions of the person served are respected and incorporated into service delivery whenever appropriate and applicable. All services meet or exceed the required standards of the Americans with Disabilities Act (ADA) and Title VI of the Civil Rights Act. Staff is also expected to conduct themselves in a manner agreeable to the diverse population served. Any special needs are to be assessed throughout treatment and referrals are to be made as clinically indicated and desired by the person served.

VIII) Staffing Structure and Resources:

a. **One (1)** Program Manager
b. **Three (3)** Behavioral Health Clinicians
c. **Three (3)** Specialized Care Coordinators
d. **Three (3)** Family Support/Peer Mentors

The Program Manager shall, at a minimum, posses: A master's degree in a behavioral health field, such as psychology, mental health counseling, social work, or marriage and family therapy; and a minimum of three years of experience working with families with behavioral health needs. Education may be substituted for experience.

The Behavioral Health Clinician shall, at a minimum, posses: A master's degree in a behavioral health field, such as psychology, mental health counseling, social work, or marriage and family therapy; and a minimum of two years of experience working with individuals with behavioral health needs.

The Specialized Care Coordinator shall, at a minimum, posses: A bachelor's degree in a social services discipline. Which includes the study of human behavior and development; and a minimum of one year of experience working with individuals with behavioral health needs; or a bachelor's degree with a major in another field and a minimum of three year of experience working with individuals with behavioral health needs.

The Family/Peer Mentors shall, at a minimum, possess at least three years of sustained recovery from addiction, and have had prior involvement with child welfare; or Certification as a Certified Peer Recovery Specialist by the Florida Certification Board.
The program will make every attempt to provide access to staff that is culturally and linguistically diverse to reflect the population served as well as provide cultural diversity training.

IX) Procedures to support Interdisciplinary Team Interaction:

One Child, One Family, One Team, One Plan
The Child and Family Team, on a practice level, is where the rubber meets the road and system of care is actively implemented to promote positive outcomes for youth and families. A Child and Family Team is built around the family to make sure that each family's strengths are promoted and their needs are met. Team members including the Peer Mentor, Clinician and Dependency Case Manager work together with the family to write an individualize plan based on what the parent/child/youth wants and needs and will include action steps to meet the dependency case plan goals.

The FITT TEAM utilizes the Wraparound process to provide specialized care coordination which uses a multi-disciplinary team to promote access to a variety of services and supports, including but not limited to: Domestic violence services; Medical and dental health care; Basic needs such as housing, food, and transportation; Educational and training services; Employment and vocational services; Legal services; and other therapeutic components of the family's treatment, services, or supports as needed.

X). Training Activities for Staff Competency:
The Specialized Care Coordinator and Peer Mentor will receive two (2) days of classroom training that lays the groundwork for "what is Wraparound." They will then spend an average of twenty (20) hours shadowing seasoned certified staff and two (2) hours of coaching per week until competency is demonstrated, typically within six (6) months of hire. Coaching is scheduled with staff to take place in the office to review work documents and in the field for live observation. Field observations occur at the family's home (or at a location chosen by the family) and are conducted at times that are convenient for youth and families served, including days, evenings and weekends. Peer supervision consists of monthly case presentations where new and seasoned staff have the opportunity to present to one another and receive feedback from their peers regarding their own Wraparound practice skills.

The Behavioral Health Clinicians will utilize and draw upon several different evidenced based practices such as Positive Parenting Program (Triple P), Cognitive Behavioral Therapy (CBT), Solution-Focused therapy, Trauma-Informed Care, Motivational Interviewing and Child Parent Psychotherapy (CPP) based upon the individualized needs of families served.

All the staff involved in the project will receive training regarding how trauma affects the lives of individuals seeking services. Upon three months of hire they will receive training in Trauma Informed Care and Motivational interviewing.

XI). *Peer Support Services:*

Peer support for crisis intervention, referrals, and therapeutic mentoring; is available 24 hours per day, seven days per week.

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XVI. Florida Assertive Community Treatment (FACT) Program

The Florida Assertive Community Treatment team is a transdisciplinary clinical team approach with a fixed point of responsibility for directly providing the majority of treatment, rehabilitation and support services to identified individuals with mental health and co-occurring disorders.

The FACT Program must be in compliance with AHCA guidelines and DCF's Guidance 16, as applicable.

- **Program Description:**
  The FACT team is recovery-oriented, strengths-based, and person-centered. The FACT team provides a comprehensive array of services for program participants, such as: helping find and maintain safe and stable housing; furthering education or gaining employment; education about mental health challenges and treatment options; assisting with overall health care needs; assisting with co-occurring substance abuse recovery; developing practical life skills; providing medication oversight and support; and working closely with individuals' families and other natural supports. The FACT team primarily provides services to participants where they live, work, or other preferred settings, and are available 24 hours a day, 7 days a week. The programmatic goals are to prevent recurrent hospitalization and incarceration, as well as improve community involvement and overall quality of life for program participants.

II) Program Goals:

1. Implement with fidelity to the Assertive Community Treatment (ACT) model,
2. Promote and incorporate recovery principles in service delivery,
3. Eliminate or lessen the debilitating symptoms of serious mental illness and co-occurring substance use that the individual may experience,
4. Meet basic needs and enhance quality of life,
5. Improve socialization and development of natural supports,
6. Support with finding and keeping competitive employment,
7. Reduce hospitalization.

Staffing Requirements:

- One full-time Team Leader,
- One part-time1 Psychiatrist or Psychiatric Advanced Practice Registered Nurse (APRN),
- One nurse for every 35 participants
- One full-time Peer Specialist,
- One full-time Substance Abuse Specialist,
- One full-time Vocational Specialist,
- One full-time Case Manager, and
- One full-time1 Administrative Assistant.

The Team Leader must be a full-time employee with full clinical, administrative, and supervisory responsibility to the team with no responsibility to any other programs during the 40-hour workweek and possess a Florida license in one of the following professions: Licensed Clinical Social Worker, Marriage and Family Therapist, or Mental Health Counselor licensed, Psychiatrist licensed, Psychologist licensed.

The Psychiatrist or Psychiatric APRN provides clinical consultation to the entire team and also monitor non-psychiatric medical conditions and medications, provides brief therapy, and provides diagnostic and medication education to participants. The Psychiatrist or Psychiatric APRN also conduct home and community visits with participants as needed. The nurse must be a full-time Registered Nurse (RN) required to be on duty Monday through Friday.

Peer Specialists must provide individualized support services and promote self-determination and decision-making. Substance Abuse Specialist must obtain a bachelor's or master's degree in psychology, social work, counseling, or other behavioral science; and two years of experience working with individuals with co-occurring disorders. Bachelor's level substance abuse specialists must be certified as a Certified Addiction Professional. Vocational Specialist must obtain a bachelor's degree and a minimum of one year of experience providing employment services.

The Case Manager provides the rehabilitation and support functions under clinical supervision and are integral members of individual treatment teams. This position requires a minimum of a bachelor's degree in a behavioral science and a minimum of one year of work experience with adults with psychiatric disabilities.

An Administrative Assistant is responsible for organizing, coordinating, and monitoring the non-clinical operations of FACT. Functions include direct support to staff, including monitoring and coordinating daily team schedules and supporting staff in both the office and field.

The FACT team conducts daily organizational staff meetings at regularly scheduled times as established by the Team Leader. The FACT team conducts treatment planning meetings under the supervision of the Team Leader.

Program Criteria:

The individual must meet one of the following seven (7) criteria:

- More than three crisis stabilization unit or psychiatric inpatient admissions within one year,
- History of psychiatric inpatient stays of more than 90 days within one year,
- History of more than three (3) episodes of criminal justice involvement within one year,
- Referred by one of the state's correctional institutions for services upon release,
- Referred from an inpatient detoxification unit with documented history of co-occurring disorders,
- Referred for services by one of Florida's state hospitals, or
- High risk for hospital admission or readmission.

The individual must meet at least three of the following six characteristics:

1. Inability to consistently perform the range of practical daily living tasks required for basic adult interactional roles in the community without significant assistance from others. Examples of these tasks include:
2. Maintaining personal hygiene,
3. Meeting nutritional needs,
4. Caring for personal business affairs,
5. Obtaining medical, legal, and housing services, and
6. Recognizing and avoiding common dangers or hazards to self and possessions.
7. Inability to maintain employment at a self-sustaining level or inability to consistently

carry out the homemaker role (e.g., household meal preparation, washing clothes, budgeting or child-care tasks and responsibilities),
8. Inability to maintain a stable living situation (repeated evictions, loss of housing, or no housing),
9. Co-occurring substance use disorder of significant duration (greater than six months) or co-occurring mild intellectual disability,
10. Destructive behavior to self or others, or
11. High-risk of or recent history of criminal justice involvement (arrest and incarceration).

The FACT team engages recipients, providing them with information about the FACT program, screen them for eligibility, allow them to make an informed decision regarding participation in FACT services. Once a recipient expresses interest in, and desire for, participation in FACT services and meets eligibility requirements, the FACT team enrolls them in the program.

The maximum number of participants (including Florida Medicaid recipients and individuals who are not Medicaid recipients) served by a FACT team is 120, unless approved by the Department of Children and Families (DCF). the FACT team must prioritize enrolling participants directly discharged from a state mental health treatment facility.

V) <u>Services & Support:</u>

The FACT team must provide the following services to the participants:

1. Crisis Intervention
2. Comprehensive Assessment
3. Natural Support Network Development
4. Case Management
5. Enhancement Funds
6. Family Engagement and Education
7. Psychiatric Services
8. Rehabilitation Services
9. Substance Use and Co-occurring Services
10. Supported Employment
11. Therapy
12. Wellness Management and Recovery Services
13. Transportation
14. Supported Housing
15. Competency Training

VI) <u>Discharge Criteria:</u>

Discharges and fall into the following categories:

- The participant demonstrates an ability to perform successfully in major role areas (i.e., work, social, and self-care) over time without requiring assistance from the program and no longer requires this level of care (i.e. successful completion).
- The participant moves out of the FACT team's service area.
- The participant requests discharge or chooses not to participate in services, despite the team's repeated efforts to develop a recovery plan acceptable to the participant.
- Following a six (6) month period in which the participant has been admitted to a state mental health treatment facility and there is no anticipated date of discharge.

- The participant has been adjudicated guilty of a felony crime and subsequently sent to a state or federal prison for a sentence that exceeds one (1) year. Otherwise the participant remains enrolled with the FACT Team.
- The participant was admitted to a nursing facility for long-term care due to a medical condition, and there is no anticipated date of discharge.
- The participant dies.

The team must document the discharge process in the participant's medical record, including:

- The reason(s) for discharge.
- The participant's status and condition at discharge.
- A final evaluation summary of the participant's progress toward the outcomes and goals set forth in the recovery plan.
- A plan developed in conjunction with the participant for treatment upon discharge and for follow-up that includes the signature of the primary case manager, Team Leader, Psychiatrist/Psychiatric APRN, and participant/legal guardian. If the FACT participant or guardian is not available to sign the discharge plan, the reason will be documented in the plan.
- Documentation of referral information made to other agencies upon discharge.
- Documentation that the participant was advised he or she may return to the FACT team if they desire and space is available.

VII) Required FACT Reports

- FACT Enhancement Reconciliation Report
  - This quarterly report displays the team's monthly expenditures of enhancement funds.
- Template 29 – FACT Report
  - This is a quarterly report to display the team's monthly census and aggregate client data
- FACT Census and Vacant Position(s) Reports due monthly

VIII) Outcome Measures:

- Percent of adults with severe and persistent mental illnesses who live in stable housing environment that is equal to or greater than 90 percent or the most current General Appropriations Act working papers transmitted to the Department of Children and Families; and,
- Average annual days worked for pay for adults with a severe and persistent mental illness that is equal to or greater than 40 days worked for pay or the most current General Appropriations Act working papers transmitted to the Department of Children and Families.
- FACT teams must incorporate the following performance measures:
- Fewer than 10 percent of all individuals enrolled will be admitted to a state mental health treatment facility while receiving FACT services.
- Within thirty (30) days of discharge from the program, fewer than 10 percent of all individuals will be readmitted to a state mental health treatment facility.
- 75 percent of all individuals enrolled will either maintain or show improvement in their level of functioning, as measured by the Functional Assessment Rating Scale (FARS).
- FACT teams must also incorporate the following process measures:
- 90 percent of all initial assessments shall be completed on the day of the person's enrollment with written documentation of the service occurrence in the clinical record.

- 90 percent of all comprehensive assessments shall be completed within 60 days of the person's enrollment with written documentation of the service occurrence in the clinical record.
- 90 percent of all individuals enrolled shall have an individualized, comprehensive recovery plan within 90 days of enrollment with written documentation of the service occurrence in the clinical record.
- 90 percent of all individuals enrolled shall have a completed psychiatric/social functioning history timeline within 120 days of enrollment

DCF Guidance for FACT:

https://www.myflfamilies.com/sites/default/files/2023-06/Guidance%2016%20FACT%202023%2007%2001.pdf

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XVII. Florida FACT Tier 4 High Acuity Treatment Team (HATT)

FACT Tier 4 (High Acuity Treatment Team, herein referred to as "HATT team"), is a team that will provide a level of care between Florida Assertive Community Team and Care Coordination team.

PROGRAM DESCRIPTION

The HATT team will deliver comprehensive care and promote independent, integrated living for individuals with serious mental illness, while facilitating the effective delivery of health care services. The HATT team will offer the participants to move through their episodes of care with the most guidance available.

The goals of HATT are :

- Serve a total of 50-60 participants, over a period of 9-12 months
- Prioritize an individual's wellness and community integration.
- Facilitate transitions from higher levels of care to the community
- Facilitate transitions from lower intensity to a higher level of care with intensity, as needed
- Decrease hospitalizations, inpatient care, incarcerations, and homelessness.
- Implement with support to the Assertive Community Treatment (ACT) model
- Promote and incorporate recovery principles in service delivery
- Eliminate or lessen the debilitating symptoms of serious mental illness and co-occurring substance use that the individual may experience
- Meet basic needs and enhance quality of life
- Improve socialization and development of natural supports
- Support with finding and keeping competitive employment

PRIORITY POPULATIONS

1. Adults who are eligible for publicly funded substance abuse and mental health services pursuant to s. 394.674, F.S.; including persons meeting all other eligibility criteria who are under insured;
2. Adults with a primary serious mental illness (SMI), substance use disorder (SUD), or co-occurring disorders who demonstrate high utilization of acute care services, including crisis stabilization, inpatient, and inpatient detoxification services
3. Adults with a SMI awaiting discharge from a state mental health treatment facility (SMHTF) back to the community.
4. Adults who do not meet criteria for FACT services may require a higher level of care than Care Coordination services.
5. Individuals with primary mental health diagnosis who are charged with a felony offense and, prior to adjudication, are referred to the HATT by duly authorized representatives of local law enforcement, local courts, the State Attorney, the Public Defender, and the Managing Entity.

HATT OVERVIEW

The above agency will provide transition services through their HATT team. The HATT team will consist of 50-60 participants that will receive services over a period of 9-12 months. The HATT team will provide an effective transition between higher levels of care and lower levels of care. The HATT team in conjunction with BBHC will focus on the individuals' needs, determine level of care, link with existing and newly identified services and supports. The HATT team will consist of a psychiatrist, therapist, care coordinator, and peer specialist. The HATT team will conduct biweekly treatment team meetings and will provide assessment/clinical services, intervention/crisis support, case management, and peer support. The HATT team will be available 24/7 for crisis issues.
The HATT team will conduct assessments, LOCUS, and develop treatment plans. Each participants' treatment plan should address all team members through one goal stated. Each goal of the treatment plan should be acknowledged by all team members and should work together simultaneously to achieve goals. All treatment plans should address discharge planning.

HATT REFERRAL PROCESS

If the criteria for the HATT team eligibility is met, follow the process below to have individuals placed on a HATT team.

Referral Process:

1. The HATT team Application Request Form link is submitted via Cognito secure link to BBHC with attachments:
   - Supporting Clinical Documentation
   - LOCUS (Level of Care Utilization System)
   - Request for Data Sharing Form
   - Release of Information for Protected Health Information
2. BBHC Adult Care Coordination Team Manager reviews Cognito application for appropriateness, for the referred level of care, pre-authorizes for screening and sends to the network Provider and referral source.

3. The provider logs referrals on Screening List, coordinates screening with referral source and provides Cognito Screening Disposition to BBHC and referral source.

4. If approved and enrolled, the provider will submit a Cognito Admission Form via link to BBHC. BBHC will provide an authorization number including start and ending date of authorization, for 6 months.

5. If approved and waitlisted, the individual will be logged on BBHC Provider waitlist until enrollment date is identified among both parties. Screening disposition will be uploaded via Cognito link. Interim Services will be identified.

6. If declined, the BBHC Provider will provide a reasoning for the decline via Cognito disposition and provide a recommendation for other services to BBHC and the referral source.

REPORTING AND PERFORMANCE MEASURES

The Department shall provide the Managing Entities with Access databases for each HATT team provider. Managing Entity subcontracts shall require the HATT team provider to enter all client data into the Access database and export the data on a monthly basis. The Managing Entity shall submit HATT team data to the Department no later than the 18th day of each month following service delivery.

Monthly and yearly service targets should be determined by the Managing Entity, taking into account capacity of the HATT Team provider, needs of families served, as well as geographical considerations. The targets should assume that families will remain in treatment and after care for several months. For additional performance outcomes, not rolled into data, the provider will submit this information in the discharge summary to the ME.

In the event the HATT Team Provider fails to achieve the minimum performance measures, the Managing Entity may apply appropriate financial consequences.

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XVIII. Community Action Treatment (CAT) Team Program

The Community Action Treatment (CAT) team provides intensive, integrated, individually tailored community-based behavioral health treatment and family-focused support services. The CAT team serves young people ages 11 through 21 who struggle with severe mental health and co-occurring substance misuse. The multidimensional Team of professionals will support clients and their families to improve the psychosocial functioning of young people across settings, to increase the ability of the family to manage and help their child with challenges related to severe emotional disturbance, and to strengthen family functioning. These improvements will reduce the occurrences of mental health crisis necessitating hospitalization, out of home placement or other highly restrictive interventions and increase health and wellness.

The CAT Team must consist of a full-time Clinical Team Leader, a Psychiatrist or Advanced Registered Nurse Practitioner (ARNP), a Registered or Licensed Practical Nurse, Therapists, a Case Manager, Therapeutic Mentors, and Support Specialists such as a Young Adult or Family Peer Specialist. The CAT Team will work collaboratively to provide comprehensive behavioral health services to address the needs of the young person and their family. It will coordinate with other service providers and assist the family in developing or strengthening their natural support system. The CAT Team is available 24/7. If interventions outside the scope of the Team's expertise or qualifications are required (i.e., eating disorder treatment, behavior analysis, psychological testing, etc.), referrals will be made to specialists, with follow-up from the Team. The CAT Team's service delivery is flexible, using a "whatever it takes" approach to assist the young person and their family in achieving their goals.

Financial Consequences:
There is a requirement to apply financial consequences if the CAT Team does not meet the monthly minimum service target. BBHC will apply a $2,000 reduction of the monthly invoice amount for each individual served less than the monthly service target, as required.

Services Include:
- Individual and family psychotherapy
- Individual and family skills training
- Crisis assistance
- Medication management
- Medication education
- Peer and family support services
- Case management and care coordination
- Psychoeducation, consultation, and coordination with the client's support system
- Clinical consultation to the client's school or employer
- Coordination with, or performance of, crisis intervention and stabilization services
- Transition services
- Housing access support
- Legal system coordination

Admission Criteria:
- The young person must be aged 11 to 21
- The young person must have a mental health diagnosis or co-occurring substance misuse diagnosis with accompanying characterizes such as: being at risk for out-of-home placement as demonstrated by repeated failures at less intensive levels of care; having two or more hospitalizations or repeated failures; involvement with the Department of Juvenile Justice or

multiple episodes involving law enforcement; or poor academic performance or suspensions.
- Children younger than age 11 may be candidates if they meet two or more of the characteristics mentioned above.

Screening, Assessment, and Procedure Requirements:
- Referrals to the CAT Team will be submitted electronically using Cognito. Documentation substantiating mental health history such as biopsychosocial, mental health records, psychological or psychiatric evaluations, etc. should be uploaded to submitted referrals.
- The Community Action Treatment (CAT) Team Disposition Form will be completed within 48 hours of contact with the client.
- Upon admission of young people to the CAT Team, the Team will complete the Program Admission Form within 48 hours of admission.
- Within 45 days of admission to the Team, the CAT provider will complete the North Carolina Family Assessment Scale for General Services and Reunification (NCFAS-G+R).
- CAT will utilize a variety of reliable and valid screening and assessment tools such as the Ca-LOCUS or LOCUS, as part of the assessment process, with a focus on screening for co-occurring mental health and substance use disorders. The screening and assessment process will identify competencies and resources as well as needs across multiple life domains, such as education, vocation, mental health, substance use, primary health, and social connections.
- Within 30 days of admission to the CAT Team, the provider will complete an Initial Plan of Care.
- Within 60 days of admission to the CAT Team, the provider will review the Initial Plan of Care and update as needed.
- After review, the Initial Plan of Care becomes the Master Plan of Care.
- The Master Plan of Care will be reviewed and revised every three months after the date of creation until discharge or as needed to address changes that impact treatment and discharge planning.
- The provider will conduct weekly CAT Team Staffing's with the entire Team in attendance to thoroughly review the young person's progress.
- The provider will staff young people with the Managing Entity every 90 days from the date of initial authorization to determine treatment progress.

To request an extension of services on the CAT Team, the provider will complete an electronic CAT Team Extension Request Form in Cognito, 30 days before the expiration date. The provider must attach the following documents with the Extension Request Form: current Ca-LOCUS/LOCUS, treatment plan, and treatment plan review, along with copies of the last four weeks of progress notes.
- After review, BBHC will schedule a staffing with the current treatment team and decide on the extension request within 24 hours.

The provider may use telehealth/telemedicine to facilitate service provision.

Models and Approaches to be utilized include but are not limited to:
- Transition to Independence Process (TIP)
- The Research and Training Center for Pathways to Positive Futures (Pathways)
- National Wraparound Initiative
- Positive Youth Development (PYD)
- Youth M.O.V.E.

Required Weekly & Monthly Reporting

- CAT providers must submit the CAT Monthly Data Reporting Template on the date specified by the ME (Managing Entity) and should include the following:
- School Attendance – Individuals receiving services shall attend an average of 80% of school days.
- CFARS (Children's Functional Assessment Rating Scales) will be used for individuals under 18 years of age and FARS (Functional Assessment Rating Scale) for individuals 18 years of age or older.
- 80% of individuals receiving services shall improve their level of functioning from admission to discharge.
- Living in a Community Setting – Individuals receiving services will spend a minimum of 90% of their days living in a community setting.
- North Carolina Family Assessment Scale for General Services and Reunification (NCFAS-G+R) - 65% of individuals and families receiving services shall demonstrate improved family functioning as demonstrated improvement in the Child Well-Being domain between admission and discharge.
- The NCFAS-G+R is not required for individuals 18 years of age and older.
- CAT providers are required to submit a Monthly Census on the 5th day of each month to the ME (Managing Entity) which includes the following:
    - Name, DOB, Peer Specialist, Therapist, Case Manager/TIP Coach, Eligibility Criteria, Medicaid/Insurance, Authorization #, Admission Date, etc. and includes names of clients admitted to Inpatient Psychiatric Units or Hospitals.
- CAT providers are required to submit a weekly CAT Waiting List and Screening List to the Managing Entity by COB each Friday which includes the following:
    - Waiting List: Name, DOB, Gender, Date Referred, Screening Date, Projected Admission Date, Interim Services, Agency Providing Interim Services, Discharge Date.
    - Pending Screening List: Name, SS#, DOB, Gender, Referral Date, Referral Source and Screening Date.

Serving Young Adults

The CAT program serves young adults up to the age of twenty-one (21), which includes young adults ages eighteen (18) up to twenty (20) who are legally considered adults. Network Service Providers serving these young adults must consider their legal rights to make decisions about their treatment, who will be involved, and with whom information will be shared. In keeping with the focus of the CAT model, Network Service Providers should support the young person to enhance and develop relationships and supports within their family and community, guided by their preferences.

Discharge

As part of the discharge planning process, CAT teams assist in the identification of additional resources that help individuals and families maintain progress made in treatment. Throughout treatment, the Network Service Provider should focus on the successful transition from services. As the individual moves into the discharge phase of treatment, the CAT Team may determine the need to modify the service array or frequency of services to ease the transition to less intensive services and supports.

Within seven calendar days of an individual's discharge from services, the Provider shall complete the CAT Team Discharge Notice via an electronic digital system such as Cognito and upload the Discharge Summary containing the following items, at a minimum:

1. The reason for the discharge;

2. A summary of CAT services and supports provided to the individual;
3. A summary of resource linkages or referrals made to other services or supports on behalf of the individual; and
4. A summary of the individual's progress toward each treatment goal in the Master Plan of Care

Refer to Guidance Document 32 for additional details

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XIX. Forensic Multidisciplinary Team (FMT)

The Forensic Multidisciplinary Team (FMT) is a service-delivery model for providing comprehensive community-based treatment to persons with severe and persistent mental illnesses and legal issues, considered to be in Chapter 916 known as ITP (Incompetent to Proceed) or NGI (Not Guilty for Insanity). The FMT team is the central point for delivering services required by each client to live successfully in the community by optimizing their independence. Delivering the needed level of support in an assertive manner, appropriate service planning and coordination, advocacy, flexibility, attention to medications and response during times of crisis are the hallmarks of this approach.

The FMT program is adapted from the ACT (Assertive Community Treatment) model. Like ACT, FMT is an intensive team comprised of multidisciplinary staff that predominantly provides all services to the individuals served. The BBHC FMT program will abide by the DCF Guidance 28 - Forensic Multidisciplinary Team

The team is comprised of a team leader, psychiatrist, nurse, peer specialist, therapist, 2 case managers and an administrative assistant. The number of staff members is directly related to the number of clients on the team. The FMT team has a maximum caseload of 45 clients at any given time. This case size assists with the provision of intensive programming with client contact of 3 times per week. Contacts could be made through various means such as face to face visits, tele-health, telephone calls and include psychiatric and medication visits. Psychiatric visits can range from 1 time a month or more often, based on client needs. 75% of services are provided in the community and non-traditional settings. These settings include client's home, parks, work areas, or other settings feasible for community integration. The team provides the majority of treatment, support and rehabilitation services and assists with the brokerage of a few specialized services as necessary. Due to the forensic and legal involvement of all individuals served, participation in the courts and other judiciary processes are amongst the many responsibilities of the team.

The program goals include:

1. Diverting individuals who do not require the intensity of a forensic secure placement from the criminal justice system to community-based care;
2. Eliminating or lessening the debilitating symptoms of mental illness that the individual experiences;
3. Addressing and treating co-occurring mental health and substance abuse disorders;
4. Reducing hospitalization;
5. Increasing days in the community by facilitating and encouraging stable living environments; and
6. Collaborating with the criminal justice system to minimize or divert incarcerations.

Admission criteria include:

- Clients must be at least 18 years of age
- Resident of Broward County for 30 days or more
- History of Psychiatric hospitalizations or demonstrates high risk for admission or re-admission or repeated crisis stabilization contacts in the past 6 months
- Determined by a court to be ITP, or NGI pursuant to Chapter, 916, F.S. or
- Person with a serious and persistent mental illness who are arrested and, prior to adjudication are referred to FMT

Staffing Standards

The FMT staffing configuration is comprised of practitioners with a diverse range of skills and expertise. This enhances the team's ability to provide comprehensive care based on the individual's needs. The FMT shall maintain a Case Manager-to-Individual ratio of no more than 1:15.

The FMT shall employ a minimum of:

- 1 Full-Time Equivalent (FTE) Licensed Team Leader;
- 3 FTE Case Managers;
- 0.5 FTE Psychiatric Advanced Registered Nurse Practitioner (ARNP) or Psychiatrist;
- 1 FTE Therapist; and
- 0.5 FTE Administrative Assistant.

Services

This service shall be available 24 hours a day, seven days per week. The team must operate an after hour on-call system at all times, staffed with a mental health professional. The frequency of service is determined by the ME, as 3 face-to-face contacts a week for each client. Telemedicine/telehealth shall be introduced within the provision of services. For example, one of the face-to-face contacts can be delivered via telehealth/telemedicine.

The FMT shall offer the following services.

a. Crisis Intervention and On-Call Coverage
b. Comprehensive Assessments
c. Case Management and Intensive Case Management
d. Medical Services
e. Substance Abuse and Co-Occurring Services
f. In-Home and On-Site Services
g. Incidental Expenses

Services can be provided via telehealth/telemedicine

The FMT Team Leader is required to provide a Monthly Census by the 5th of each month; and a Weekly Waiting list to the BBHC Forensic Coordinator, by Friday at Noon. In addition, by the 15th of each month, they shall submit the data elements required by Template 25 - Forensic Multidisciplinary Team Report. All these reports will be sent to the BBHC Forensic Coordinator.

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XVIII. Central Receiving System (CRS)

BBHC has created a Central Receiving System in accordance of Guidance 27 - Central Receiving Systems Grant, which is the overarching rule.

PROGRAM DESCRIPTION: The Centralized Receiving System is designed to provide adults experiencing a crisis a convenient point of entry into the mental health and substance use systems for immediate assessment as well as subsequent referral and linkage to appropriate and available providers and services. Individuals will be assessed for care based on a triage model of urgency, in which concerns for safety to self and to others based on Baker Act criteria and Marchman Act criteria are addressed first.

The goals of the CRS are to:

- Provide initial assessments, triage, case management and related services;
- Provide opportunities for jail diversion, offering a more suitable and less costly alternative to incarceration;
- Reduce the inappropriate utilization of emergency rooms;
- Increase the quality and quantity of services through coordination of care and recovery support services;
- Implement standardized assessment tools and procedures for services; and
- Improve access and reduce processing time for law enforcement officials transporting individuals needing behavioral health services.

The LOCUS (Level of Care Utilization System) and SPDAT (Service Prioritization Decision Assistance Tool), standardized assessment tools, will be utilized for further determination of needs. Individuals will be offered referral and/or linkage to appropriate providers and services based on their desired need(s) as well as the professional determination of evaluating staff.

The CRS provides opportunities for jail diversion, offering a more suitable and less costly alternative to incarceration; reduce the inappropriate utilization of emergency rooms; increase the quality and quantity of services through coordination of care and recovery support services; demonstrate improved coordination of care and improvements in client outcomes; and improve access and reduce processing time for persons served and law enforcement officials transporting the target population. Henderson Behavioral Health's CRS is aligned with The Triple Aim of improving population health and the patient experience of care, while reducing per capita cost.

Location

The Centralized Receiving Center (CRC) will be located at Henderson Behavioral Health, Headway Office Park Location, 4720 North State Road 7, Building B, Lauderdale Lakes, Florida 33319. The Center will be open 24/7/365 days of the year to provide immediate access to emergency services and Coordination of Care for the targeted population for Law Enforcement and Hospital Emergency Departments.

The CRC will be one of four multi-entry drop-off sites currently identified for Law Enforcement to bring individuals, and is designed for those not meeting the criteria for involuntary hospitalization under the Baker Act or Marchman Act;

- Memorial Regional Emergency Room in Hollywood,

- Broward Addiction Recovery Center (BARC) and
- Henderson's Crisis Stabilization Unit are also identified "drop-off" sites.

Targeted Population

Adults male and female, over 18 years of age, with behavioral health and/or substance use issues who are in need of an involuntary evaluation or stabilization under a Baker Act or Marchman Act as well as Crisis Support services as defined in subsections 394.67 (170-(18), F.S. "Crisis services" means short-term evaluation, stabilization, and brief intervention services provided to a person who is experiencing an acute mental or emotional crisis to prevent further deterioration of the person's mental health and whom may give informed consent for voluntary treatment.

Other characteristics that are typical of the targeted population may include:

- High risk of over-reliance on utilizing the most costly and restrictive levels of care, including emergency rooms, crisis stabilization units, repeated &/or prolonged psychiatric hospitalizations, and intermediate or long-term institutionalization;
- Involvement in the judiciary system due to various misdemeanor and felony charges, often leading to incarceration;
- Episodic or chronic homelessness, often precipitated by lack of access to affordable, safe and decent housing of their choice.

Eligibility/ Entry Criteria:

1. Age 18 and older
2. Residents of Broward County
3. Those who are experiencing a substance abuse or a severe psychiatric or emotional episode of crisis or have a severe and persistent major mental illness, (i.e. schizophrenia, schizoaffective disorder, bipolar disorder, or major depression), that had been identified by Law Enforcement and/or Hospital Emergency Departments and do not meet criteria to be admitted for inpatient care.

Services Provided:

1. Psychiatric/diagnostic evaluations
2. Crisis counseling and intervention
3. Outpatient Therapy
4. Assessment of co-occurring disorders
5. Case Management and/or Care Coordination
6. Recovery Support
7. Linkage and referral
8. Evaluation and arrangement for inpatient hospitalization, as necessary

Transition and Discharge:

A Transition/Action Plan shall be completed by the practitioner/treatment team, with the person served, and when applicable, a family/significant other, when the person may benefit from a different level of care and/or additional services within Henderson Behavioral Health (HBH) or is being discharged from the program/organization.

Performance Measures

Subcontracts must adopt, at a minimum, performance measures to evaluate the impact of the CRS project within the community. Per Section 2.4 of the RFA, and as detailed in Tab 4 of the grantee's

application, performance measures and methodologies must be related to the grantee's specific CRS project and must include, at a minimum, measures to address the following outcomes:

- Reduce drop-off processing time by law enforcement officers for admission to crisis services;
- Increase participant access to community-based behavioral health services after referral;
- Reduce the number of individuals admitted to a state mental health treatment facility
- Two additional output, process, or outcome measures tailored to the specific CRS project.

Reports:

4. Detailed Quarterly Report compiling the monthly data.

I) Project Status Report: Monthly report due by the 5th of the month consisting of the following subsections:

A. Data/Outcome measures reported for each month and since inception:

b) Number of individuals served at each CRS location, including Memorial ER, BARC, Henderson CSU and the Henderson CRC facility;
c) Number of individuals seen at Community Court
d) Number of individuals diverted from Hospitalization
e) Number of individuals assisted with SOAR applications
f) Percent of individuals linked with Community Resources
g) Number of MOU's
h) Number of SPDATs
i) Number of HOH Opioid Referrals
j) Estimated savings to the Legal system
k) Estimated Savings to the Behavioral Health System

B. Community Education/Outreach:

- Number of Community Presentations/Collaborative
- Meetings/Attempted
- Contacts/Law Enforcement Education/Roll Call

C. Referral Sources: Breakdown including subsections:

- Hospitals
- Law Enforcement Municipalities
- Broward Sheriff's Office by City

Monthly Client Volume including number individuals served in Graph format

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XX. Mobile Response Team (MRT)

The Mobile Response Team (MRT) provides on-site behavioral health crisis intervention services to children, adolescents and adults in any setting in which a behavioral health crisis is occurring, including homes, schools and emergency departments. Mobile response services are available 24/7 by a team of professionals and paraprofessionals, who are trained in crisis intervention skills to ensure timely access to supports and services. In addition to helping resolve the crisis, teams work with the individual and their families to identify and develop strategies for effectively dealing with potential future crises. MRT providers are responsible for working with stakeholders to develop a community plan for immediate response and de-escalation, but also crisis and safety planning. Stakeholder collaboration must include law enforcement and school superintendents, but may also include other areas within education, emergency responders, businesses, other health and human service related providers, family advocacy groups, peer organizations, and emergency dispatchers (i.e., 211 and 911 lines). Telehealth/telemedicine shall be utilized to facilitate and expedite this emergency response.

I) The MRT provides behavioral health crisis intervention services to young people who meet at least one of the following criteria:
II) Have an emotional disturbance;
III) Are experiencing an acute mental or emotional crisis;
IV) Are experiencing escalating emotional or behavioral reactions and symptoms that impact their ability to function normally within their environment; or
V) Are served by the child welfare system and are experiencing or are at high risk of placement instability.

The MRT must complete the following activities:

- Triage and prioritize requests, then, to the extent permitted by available resources, respond in person within 60 minutes of prioritization;
- Respond to a crisis in the location where the crisis is occurring;
- Provide behavioral health crisis-oriented services that are responsive to the needs of the child, adolescent, or young adult and his or her family and enable them to deescalate and respond to behavioral health challenges through evidence-based practices;
- Provide screening, standardized assessments, early identification, and referrals to community services;
- Provide care coordination by facilitating the transition to ongoing services;
- Ensure a process for informed consent and confidentiality compliance measures is in place;
- Promote information sharing and the use of innovative technology; and Coordinate with the ME and other key entities providing services and supports to the child, adolescent or adult and their family;;
- Conduct a minimum of seven (7) formal outreach activities conducted annually;
- Report to BBHC on the performance outputs and the number of individuals who did not require an involuntary examination that were actively linked to the appropriate level of care with a community provider for ongoing behavioral health services.

All BBHC Contracted Providers must provide contact information for MRTs to parents and caregivers of children, adolescents, and young adults between the ages of 18 and 25, who receive safety-net behavioral health services. This initiative is guided by the DCF MRT Guidance 34 Document that can be found at the following link: https://www.myflfamilies.com/service-programs/samh/managing-entities/2023-contract-docs.shtml

XXI. Mothers In Recovery (MIR)

The MIR treatment and prevention program is designed to reduce the number of babies born with Neonatal Abstinence Syndrome due to opioid exposure in utero. This aim will be achieved through targeting prevention and treatment strategies for pregnant women, women with dependent children and women of childbearing age through a three-pronged process:

a. Community outreach and education regarding substance use disorders, comorbid mental health disorders, the dangers of drug and alcohol use during pregnancy, and providing referral information.
b. Universal screening during medical encounters—emergency department visits, primary care visits and OB/GYN visits in order to provide brief intervention and linking with treatment.
c. Outpatient substance abuse treatment provided through collaborative/integrated services including motivational enhancement therapy, cognitive skills therapy and relapse prevention, and trauma informed care.

Deliverables

a. Staffing
b. Equipment
c. Program Implementation
d. Outpatient Treatment Services
e. Outreach and Education Services
f. Program Outcome Reports

Program Outcomes

Method	Outcome	Measurement
Provide substance abuse prevention education & outreach	100 women will be provided with substance abuse prevention education and referral information.	Electronic Health Record (EHR) documentation of patient outreach encounters, sign in sheets for group education and outreach events
Provide universal screening for substance use disorders	100 women will be screened for substance use disorders using evidence-based screening tools	Electronic Health Record (EHR) documentation of completed screening
Provide evidence-based outpatient substance abuse treatment	50 women will receive integrated substance abuse treatment focused on motivational enhancement, skill building and relapse prevention	Electronic Health Record (HER) documentation, urine toxicology results, group sign in sheets
Reduce the incidence of Neonatal Abstinence Syndrome	75% of women who receive MIR services will give birth to neonates born drug free.	EHR documentation

XXII. Medication Assisted Treatment (MAT) Program

The BBHC Medication Assisted Treatment (MAT) Program includes person centered, recovery-oriented, and comprehensive care model to treat persons with opioid use disorders that features a phased treatment approach. The phase model assumes that although some clients need long-term MAT, the types and intensity of services they need vary throughout treatment and should be determined by the individual needs of the client. The four general phases of MAT are induction, stabilization, maintenance, and discontinuation/sustained recovery. The services provided in each phase of treatment are defined by clinical needs and programmatic considerations.

The goals for each phase are as follows:

1) Induction phase—medically monitored startup of buprenorphine, long-acting naltrexone, and/or other MAT medications;
2) Stabilization phase—address cravings and triggers, develop a long-term recovery plan. The stabilization phase should include integrated primary care services;
3) Maintenance phase-- with ongoing peer support, medication management and a compendium of supportive services;
4) Discontinuation/Sustained Recovery Phase—this the final phase where the client is given the choice/opportunity to discontinue medication while still receiving supportive services.

Peer support services are utilized throughout all phases of the program.

BBHC MAT programs will prioritize the high-risk populations: pregnant women, intravenous drug users, women with dependent children aged 0-5, caregivers/parents involved in the child welfare system, minorities, persons with HIV/AIDS, and consumers with criminal justice involvement. A Recovery-Oriented Systems of Care model is utilized to provide comprehensive, continuous care to treat the consumer during all phases of MAT treatment.

BBHC MAT programs may utilize the following evidence-based models, not limited to: 1) Emergency Initiation of MAT; 2) Medicaid Health Home Model for the Treatment of Opioid Use Disorders; and 3) Detoxification – Office-Based Opioid Treatment.

BBHC MAT Programs will include both medication maintenance with Subutex (Buprenorphine), Suboxone (Buprenorphine/Naloxone) or Vivitrol (Naltrexone) and medication-assisted detoxification/taper with Subutex or Suboxone. Additional services should include a harm reduction program for caregivers and consumers who are trained on the proper use of the Narcan Kits. Consumers will receive treatment that is integrated and coordinated within all primary, acute, and behavioral health settings.

Following is a brief overview of the BBHC MAT Services and Phases of Treatment:

MAT services include:

- Aftercare
- Case Management
- Crisis Support/Emergency
- Day Treatment
- Incidental Expenses (excluding housing/rental assistance and direct payments to participants)
- In-Home and On-Site

- Medical Services
- Medication-Assisted Treatment (methadone maintenance, buprenorphine maintenance or oral naltrexone)
- Outpatient
- Outpatient Detoxification
- Outreach (to identify and link individuals with opioid use disorders to medication-assisted treatment providers)
- Recovery Support
- Supported Employment
- Supportive Housing/Living
- Substance Use Detoxification
- Residential Treatment

I. Coordination of Care and Integrated Treatment

BBHC MAT services will prioritize care coordination through all levels of care, health promotion through integrated primary/behavioral health clinic, transitional care/follow up services, peer recovery support services, consumer and family support, access to consumer-run Drop-In Centers and comprehensive substance abuse and mental health treatment. The MAT teams will ensure that consumers with opioid use disorders who are seeking treatment will have access to evidence-based, medication assisted treatment services.

II. Focus on Engagement and Access to Treatment

In order for MAT to be effective, it must be readily accessible. The first goal of MAT is to engage individuals diagnosed with opioid use and/or stimulant use disorder in treatment. All MAT programs should have a targeted approach to outreach and providing recovery support to persons in need of services. Peer specialists are key staff who can provide initial care coordination, identify and begin to address immediate needs and help increase motivation for treatment.
In addition, BBHC has focused on improving access to MAT services for these by improving infrastructure and collaboration among treatment providers at all levels of care. MAT programs should design programs that focus on effective and expedited access to medication to optimize engagement in treatment and promote retention.

III. Phased Treatment Approach

Best practice for MAT recommends that medication-assisted treatment is conceptualized in terms of phases of treatment so that interventions are matched to levels of client progress and intended outcomes. A phased treatment approach is outcome-oriented and engages clients, program staff and community resources through a series of successive, integrated interventions, with each phase built on another and directly related to client progress. Such a model helps staff understand the complex dynamics of MAT, helps better address the potential challenges that may arise, and helps organize interventions based on client needs.

The phases of treatment are as follows:

1. **Induction Phase (2-4 week induction period, includes Assessment and Medical Services).**
   The induction phase is the initial period—treatment is focused on starting buprenorphine

or other MAT medications and eliminating use of illicit opioids and abuse of other psychoactive substances while lessening the intensity of the co-occurring disorders and addressing the medical, social, legal, family, and other problems associated with addiction. It is recommended that more intensive services are provided during the induction phase, especially for clients with serious co-occurring disorders or social or medical problems. Services may include:

- Psychiatric evaluation
- Physical examination
- Biopsychosocial/ Initial treatment plan
- Labs
- Medication Reconciliation
- Daily Clinic Visit
  - Medication Administration/Observation
  - Medication Management
  - Medication Education
  - Evidence Based Assessment
- Individual Recovery Support

2. Stabilization Phase (4-6 weeks)

The stabilization phase is focused on stabilizing the dosage of MAT medication. During this phase, co-occurring psychiatric disorders and medical conditions should also be addressed. The goal of this phase is to control cravings, address triggers and begin to develop a long-term recovery plan. Services may include

- Group Therapy
- Psychiatric evaluation
- Psychiatric follow up/medication management
- Medication Assisted Treatment
- Medications
- Individual therapy
- Labs (urine toxicology)
- Recovery support (group and individual)
- Primary Care Services

3. Maintenance Phase (2 - 4 months)

The primary goal of the maintenance phase of treatment is to empower clients to cope with their major life stressors—drug or alcohol abuse, medical concerns, co-occurring disorders, vocational and educational needs, family dynamics, and legal issues—so they can pursue longer term goals such as education, employment, and family reconciliation. Targeted trauma services should be provided during this phase. Quality of life issues such as stable, recovery-oriented housing, establishing recovery supports in the community, vocational rehabilitation and developing values-based life goals should be addressed in the maintenance phase. Services may include:

- Medication Assisted Treatment
- Intervention Services (individual therapy)
- Aftercare groups & Individual Recovery Support
- Labs (urine toxicology)
- Medications
- Primary and specialty medical services

4. Discontinuation/Sustained Recovery Phase (30-90 Days):

It is important that any decision to taper from opioid treatment medication be made without coercion and include careful consideration of a client's wishes and preferences, level of motivation, length of addiction, results of previous attempts at tapering, family involvement and stability, and disengagement from activities with others who use substances. A client considering dose tapering should understand that the chance of relapse to drug use remains and some level of discomfort exists even if the dose is reduced slowly over months.

BBHC MAT program services must be more responsive and increased in frequency and/or intensity during the discontinuation phase to address the psychological components of addiction, and to ensure support for long-term recovery. Peer services are particularly well-suited during this phase. As medication is being tapered, intensified services should include counseling, peer recovery support and monitoring of client's behavioral and emotional conditions. Clients considered for medication tapering should demonstrate sufficient motivation to undertake this process, including acceptance of the need for increased behavioral interventions. Tapering from medication can be difficult, and clients should understand the advantages and disadvantages of both tapering from and continuing on medication maintenance as they decide which path is best for them. Individuals who are determined to need ongoing MAT maintenance will be referred to an appropriate provider in the community that can best meet their needs. BBHC MAT providers will ensure the provision of supportive services throughout the transition.

Long-acting Naltrexone treatment for 6-9 months may be a viable option at the end of the discontinuation phase for those individuals who meet the criteria.

Aftercare services should be initiated during the tapering phase and include a focus on linking with community supports, reinforcing the need for ongoing preventive medical care, and an emphasis on establishing participation in fellowship meetings and the development of long-term plans for continued progress in recovery.

5. Government Performance and Results Modernization Act of 2010 (GPRA)

Providers of treatment and recovery support services are required to collect data at five data collection points:

1. Baseline:
    - Residential Facilities - must be completed within 3 days after the individual enters the program.
    - Non-Residential - must be completed within 4 days after the individual enters the program.
2. 6 months post intake follow-up:
    - The window period allowed for GPRA follow-up interviews is one month before the (3 or 6 month) anniversary date and up to two months after the (3 or 6 months) anniversary date.
3. Discharge:
    - Discharge interviews must be completed on the day of discharge, regardless of length of stay in the program (i.e. 1 day length of treatment still needs a discharge GPRA completed).

- If an individual has not finished treatment, drops out, or is not present the day of discharge, the project will have 14 days after discharge to find the individual and conduct the in-person discharge interview. If the interview has not been conducted by day 15, conduct an administrative discharge. For an administrative discharge when the interview is not conducted, interviewers must complete the first four items in Section A (Client ID, Client Type, Contract/ Grant ID, Interview Type), Section J (Discharge), and Section K (Services Received) and mark that the interview was not completed.

4. 3 months post- discharge:
    - Can be performed by the peer
5. 6 months post-discharge:
    - Can be performed by the peer

MAT Programs and EMS Collaboration: Consumers that have overdosed and presented in the emergency department will be offered MAT and will be visited daily for up to seven days by local EMS staff and a MAT Program Recovery Support Specialist. These staff will provide a daily dose of medication and link the consumer to ongoing recovery treatment services and the MAT Program.

Hospital Bridge programs, which initiate medication assisted treatment (MAT) services in the Emergency Department and link individuals to longer-term care through a community-based network MAT service provider,

DCF Guidance and Overview can be found on the DCF website in the Florida State Opioid Response Project Overview:
https://www.myflfamilies.com/services/samh/samh-treatment-services-and-facilities/fsorp#:~:text=Florida's%20State%20Opioid%20Response%20(SOR,misuse%2C%20disorders%2C%20and%20overdoses.

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XXIII. Competency Restoration Program (CRT)

Competency Restoration Training (CRT), utilizing the United States Supreme Court "Dusky" standards for determining a defendant's competence to proceed to trial. The training uses experiential techniques appropriate for the developmental capacity of participating clients to provide education on the legal system to include consideration of charges, penalties, court personnel, verdicts, possible pleas, relevant testifying, assisting legal counsel and appropriate courtroom behavior.

CRT accepts referrals from the Court for clients who have been adjudicated Incompetent to Proceed (ITP) and therefore ordered to complete CRT. Classes may be conducted with no more than 15 participants. During the first session, participants complete opening paperwork and are advised of participation requirements; applicable policies and procedures, class schedule; and complete a Pre-Test. Classes are conducted in community sites that are reasonably accessible via public transportation, the office location, and other locations as determined appropriate by BBHC or utilizing online communication platforms. When ordered by the court, the Provider will provide CRT to individuals in the jail. The Provider must make every attempt to assign clients enrolled in CRT to a location closest to his/her home or service provider.

Clinical staff shall conduct ongoing testing and assessment of clients' progress toward restoration and shall provide reports advising all parties if an individual has achieved maximum benefits from the training. Progress reports detailing client's attendance and participation in training will be submitted to the Court, during scheduled hearings.

CRT cycles will be 12 weeks long, and clients will be assessed after completion of the first cycle. If it is determined that the individual requires additional training, they will be ordered to complete a second cycle of CRT.

Once the Provider has determined that a client has been restored to competency or remains incompetent after a second cycle (non-restorable), they will submit copies of their assessment to the court, SAO & defense counsel with the recommendation to vacate the order for CRT. The Provider will continue to provide CRT until otherwise ordered by the Court, or unless advised by BBHC.

The Provider shall submit the CRT Tracking Log and the CRT Placements Log to BBHC by the 5th of every month.

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XXIV. Adult Post-Arrest Diversion Program

This program is designed to divert individuals charged with 3rd degree or 2nd degree non-violent felonies who experience serious mental illnesses (SMI, e.g., schizophrenia, schizo-affective disorder, bipolar disorder, major depression, or post-traumatic stress disorder) or co-occurring serious mental illnesses and substance use disorders, from the Criminal Justice System into comprehensive community- based treatment and support services. All participants must meet the clinical criteria as well as the legal criteria, and The Public Defender (Defense Attorney) and the State Attorney must provide approval for program participation.

1. APPLICATION

Applicants for entry into the Felony Mental Health Post-Arrest Diversion Program must be referred to the State Attorney's Office by the public defender, defense council, and BBHC via Cognito Forms. Applicants must be diagnosed with a Severe Mental Illness and meet all other requirements listed below. Once the case is approved by State Attorney's Office, case will be sent to the Provider for processing.

2. PAST ADULT OFFENSE HISTORY

The State Attorney's Office will review, on a case-by-case basis, applicants with up to five prior misdemeanors and up to one prior felony (arrest or disposition) where the applicant's mental health was a factor in the commission of those crime(s). The SAO will ultimately decide on client's eligibility to participate in the program.

3. PAST JUVENILE OFFENSE HISTORY

Applicants who are twenty-five (25) years of age or younger who have extensive prior criminal juvenile record (up to five prior misdemeanors and up to one prior felony arrest or disposition), will be reviewed for entry into the program on a case by case basis.

4. OFFENSE

The criminal offense for which the applicant has been arrested or charged must be a nonviolent third degree felony. Any charge involving a firearm is excluded. However, other criminal offenses will be evaluated on a case by case basis at the discretion of the State Attorney's Office.

5. CONSENT OF VICTIM(S) REQUIRED

The victim(s) of the offense for which the applicant was arrested must consent to the applicant participating in the program.

6. RESTITUTION REQUIRED

If a person or an insurance carrier, suffered monetary loss that can be determined without controversy as a direct result of the commission of the offense for which the applicant was arrested, the applicant must be ready, willing and able to make full restitution.

7. WAIVER OF RIGHTS REQUIRED

If an individual desires to be considered for entry into the program, upon applying for entry into the program and prior to any further processing of such application, the applicant must voluntarily, knowingly and intelligently execute a document to be provided that they he/she has been fully advised of his/her right to a Speedy Trial and has agreed to waive the right to a Speedy Trial on the said offense. The applicant shall waive his/her right to a Speedy Trial until the applicant successfully completes the program or is terminated from the program. At the

time of application for entry into the program the applicant's attorney shall confirm in writing that they has advised the applicant of these same rights.

The applicant voluntarily, knowingly, and intelligently waives the filing of formal charges and/or information related to their arrest and all-time requirements or limitation under the law for filing same.

The applicant waives any and all laboratory testing of the evidence related to their arrest including but not limited to testing of controlled or chemical substances, DNA, fingerprint comparison, and or trace evidence, unless this agreement is terminated, and criminal charges are filed.

8. SPECIAL CONDITIONS

a. The applicant must agree to participate in any counseling programs or group counseling sessions required by their case manager for satisfactory completion of the diversion program.
b. The applicant will sign medical and mental health release forms for medical and mental health records to allow the program case manager, the State Attorney's Office, the Court, and their attorney access to review the medical and mental health records, and reports as they relate to qualification and participation in this program.
c. The participant agrees to appear for all required appearances as required by the Felony Mental Health Post-Arrest Diversion Program, the State Attorney's Office, or the Court.

9. FAILURE TO COMPLY

The failure to comply with any of the requirements of the program or any conditions of release will result in termination and removal from the program at the discretion of the State Attorney's Office and is not reviewable by the court. The case will then be reviewed and considered for filing of the criminal charges. Post Arrest Diversion Program

The Post Arrest Diversion team is responsible for submitting a monthly report including: census, number of graduations/terminations, number of assessments completed, and a total of clients who completed orientation for each month. The report is due to BBHC by the 5th of every month.

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XXV. Crisis Intervention Team (CIT) Program

Crisis Intervention Team (CIT) began in Memphis in the late 1980s and has been widely adopted around the country. CIT is an effective law enforcement response program designed for first responders who handle crisis calls involving people with mental illness including those with co-occurring substance use disorders. CIT emphasizes a partnership between law enforcement, the behavioral healthcare and treatment systems, mental health advocacy groups, and consumers of mental health services and their families.

CIT, "The Memphis Model", was developed around a set of core elements which have led to the success of this program. Absent these core elements, we believe a law enforcement response to those in crisis with a mental illness will be less effective.

Background:
In an effort to be pro-active, the Department of Children and Families/Substance Abuse and Mental Health Program Office in partnership with BBHC contracted community Providers of Broward County brought in Major Sam Cochran and Dr. Randy Dupont from Memphis to conduct a two-day presentation on their model. Local mental health and substance abuse providers were invited along with every law enforcement agency in the county, consumers, and family members, state and county personnel, and other advocates. A series of meetings were held to determine how to move forward with this project.

The Fort Lauderdale Police Department enthusiastically stepped forward to serve as the pilot project for CIT in Broward County. Because of their unique homeless outreach activities and concerns for how people are treated, they embraced the program.

A team of dedicated individuals formed the CIT Development Workgroup comprised of, Fort Lauderdale Police Department, BBHC contracted community Providers, Department of Children and Enforcement, the Florida Council for Community Mental Health and the Florida Alcohol and Drug Abuse Association.

About three years ago, CIT of Broward expanded the training to detention deputies. Every year, two cohort groups participate in CIT program specifically designed to meet their unique needs and their role in our current system of care.

Goals for Florida CIT Programs:
CIT is a community partnership between law enforcement agencies, the local mental health and substance use treatment systems, mental health advocacy groups, and consumers of behavioral health care services and their families. CIT is more than just a training. It establishes teams of trained officers within each law enforcement agency to respond effectively to people with mental illnesses, including those with co-occurring substance use disorders that are in crisis.

Communities which establish CIT programs do so with the following goals in mind

- Better prepare police officers to handle crises involving people with mental illnesses, including those with co-occurring substance use disorders.
- Increase law enforcement officer safety, consumer safety and overall community safety.
- Collaboratively, make the mental health system more understandable, responsive, and accessible to law enforcement officers to the greatest extent possible with community resources.

1. Supply law enforcement officers with the resources to appropriately refer people in the need of care to the mental health/substance use treatment system.
2. Improve access to mental health/substance use treatment in general and crisis care in specific for people who are encountered by law enforcement.

The **monthly** training coordinated by United Way of Broward County emphasizes the understanding of mental illnesses, including substance use disorders and how it affects a person's life, the development of communication skills, practical experience and scenario-based training. Officers are able to learn from and engage with mental health professionals, consumers and family members both in the classroom and in the field during site visits.
This intensive training attempts to provide a common base of knowledge about mental illness and give the officers a basic foundation from which to build. The course is intended to provide officers with skills to:

- Recognize signs and symptoms of mental illness and co-occurring disorders.
- Recognize whether those signs and symptoms represent a crisis situation De-escalate mental illness crisis.
- Know where to take consumers in crisis.
- Know appropriate steps to follow up, such as contacting case managers, providing families with community resources, etc.
- Learn how to problem-solve with the treatment system.
- Recognize the needs of special populations (LGBTQ and Veterans) and how to successfully intervene in a way that is culturally responsive.
- Understand what autism is and how people are affected by it, various challenges when interacting with someone on the autism spectrum, and strategies to help reduce stress and or anxiety in people with autism.

CIT Broward Curriculum:

1. Introduction
2. Clinical Issues Related to Adult Mental Health
3. Legal Issues and Processes – Baker Act & Marchman Act
4. Clinical Issues Related to Elderly Care
5. Youth Mental Health
6. Development Disabilities
7. Autism
8. LBGTQ related issues
9. Personality Disorders
10. Post-Traumatic Stress Disorders
11. Suicide Prevention and Intervention
12. Crisis Intervention
13. Crisis Communication & De-escalation
14. Scenario Based Training
15. Self-Care
16. Resource Panel
17. Consumer & Family Panel

Monthly trainings could not take place without the full engagement of community partners, who provide experts to present on various topics, role players for scenario based training segment, consumers and family members for panels, and facilities to tour during the site visit segment of the week. CIT Broward thrives because it engages our entire system of care. Refresher trainings are also provided periodically.

XXVI. SOAR Requirements

OUTREACH, ACCESS, AND RECOVERY (SOAR)

SOAR is a national project funded by the Substance Abuse and Mental Health Service Administration (SAMHSA) that is designed to increase access to SSI/SSDI for eligible adults with mental illnesses who are homeless or at-risk of homelessness. BBHC, as part of a DCF Statewide Initiative, is responsible to assure that the SOAR process is implemented within our region in collaboration with key stakeholders. BBHC SOAR programs are in alignment Guidance 9 - Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach Access, and Recovery (SOAR)

Access to SSI/SSDI is a major tool in recovery from mental illness and homelessness. Without these benefits, it is extraordinarily difficult for individuals we serve to engage in treatment, to keep appointments, to maintain housing, enter the workforce, and to meet other basic needs. The goal of the SOAR process is to reduce or eliminate homelessness by reducing financial barriers that impede recovery. The SOAR process assists a defined target population: adults with mental illnesses or co-occurring disorders who are homeless or at risk of homelessness. The process assists these individuals by increasing access to SSI/SSDI benefits.

The online SOAR *Stepping Stones to Recovery* training provides all staff a good introduction to the SOAR processes. Trainings focus on the initial application and thorough documentation of the disability using a Medical Summary Report to avoid appeals, reduce the need for consultative exams, increase approval rates, and reduce times to decisions. The SOAR online training can be accessed using the following link https://soarworks.samhsa.gov.

To this end, BBHC has employed a SOAR Local Lead who has completed the SOAR online training and is available to provide technical assistance, in collaboration with DCF and the SAMHSA funded SOAR Technical Assistance Center. The ME's SOAR Local Lead also identifies other local team leads and trainers available in the area to assist as needed.

Requirements:

1) BBHC network service providers that offer adult case management and outreach services to persons with mental health and/or co-occurring disorders must designate one (1) primary SOAR representative who is responsible for the provider-level SOAR implementation initiative and who is responsible for solely processing SOAR applications, reporting to, and coordinating with the ME for SOAR contract compliance.
   - SOAR initiative targets mental health primary individuals where substance use is not material to diagnosis.
2) SOAR caseworker supervisors must complete the SOAR online training for an introduction to SOAR and to aid in supervision.
3) Documentation of the SOAR online training Certificate of Completion will be maintained in the personnel file and submitted to BBHC.
4) Providers must report data and outcomes to the BBHC SOAR Lead and SOAR Technical Assistance Center using the Online Application Tracking (OAT) system including:
   - Number of SOAR-assisted SSI/SSDI applications;
   - Decisions on applications, including appeals; and

- Numbers of days until applications are approved from date of application submission to date of decision.

5) SOAR trained staff must complete the online training or a qualified refresher training every three (3) years.
6) Complete and submit SOAR quarterly reports to BBHC SOAR Local Lead in alignment with the BBHC Fiscal Year, gathered from OAT Tracking System entries.
7) SOAR trained staff must attend the regularly convened local SOAR Managers and Processors meetings.

Outcomes:

1) Each dedicated SOAR caseworker is required to assist with at least 30 SSI/SSDI applications per fiscal year.
   a. Assign a Network Service Provider staff member responsible for data submission quality control;
   b. Enter 100% of the SSI/SSDI application data into the SOAR Online Application Tracking (OAT) program available at: https://soartrack.samhsa.gov .

2) BBHC-contracted agencies that provide services to CoC-funded Permanent Supportive Housing participants must use the SOAR screening tool, *Identifying SOAR Applicants*, to evaluate at least 90% of BBHC-funded PSH participants if the persons served meets any of the following criteria:
   a. Reporting zero income
   b. Working but earn less than the substantial gainful activity level
   c. Using BBHC Incidental Funds to pay for housing-related expenses (rent, utilities)

3) BBHC-contracted agencies that provide services to CoC-funded Permanent Supportive Housing participants must assist 90% of PSH participants who are determined SOAR eligible based on the screening tool to apply for SSI/SSDI.

4) Require all Providers which serve the target population to:
   a. Complete all SSI/SSDI applications within 60 days of the protective filing date, defined as the time when an applicant first contacts the Social Security Administration indicating an intent to file for SSI/SSDI;
   b. If applicable, complete the appeal process for those applications which may be denied upon initial review;
   c. Maintain a minimum completion rate of 75% of applications are completed and submitted within 60 days of the Protective Filing Date;
   d. Maintain a minimum rate of 65% of submitted applications are approved on the initial submission; and
   e. Achieve a negotiated minimum quarterly target for completed SSI/SSDI applications that is determined and agreed on by both parties.

More information on SOAR can be found on the national website:
https://soarworks.samhsa.gov

1. School Behavioral Health Services Program (SBHSP)

The School Behavioral Health Services Program (SBHSP) is a collaboration between the Broward Behavioral Health Coalition, Inc. (BBHC) and the School Board of Broward County (SBBC). This program aims to improve behavioral health outcomes for Broward County's students and their families by strengthening connections within the community through the use of developmentally appropriate and individualized behavioral health services. BBHC strives to foster an innovative, person-specific approach and collaborative model of care to meet the needs of the students and their families. The criteria to receive services through the SBHSP is that a student must reside in Broward County, attend a district public school in Broward County, and be diagnosed with or suspected of meeting a behavioral health disorder criterion.

This initiative ensures that students who experience difficulties due to behavioral health issues receive effective and developmentally appropriate services to meet their needs. This initiative also increases the collaboration and communication between the behavioral health and school systems for enhanced coordination of services and support for students and their families.

Referral & Enrollment Process

In order to meet the behavioral health needs of the diverse district student population within Broward County, district students requiring behavioral health services will be identified and referred by school level or district level personnel to BBHC's Intake Coordinator, via the BBHC Online Portal.

Referral and Care Coordination Services

Upon referral from SBBC, BBHC's designated Intake Coordinator will review the referral. The Intake Coordinator will determine the necessary services required by the student, identify the best available service provider within the provider network capable of addressing the needs identified for the student and any parental preferences. The student will be assigned to the appropriate network provider via the BBHC Online Portal. The Intake Coordinator will facilitate the introduction of the student and their family to their assigned provider, who will conduct the Biopsychosocial Assessment and Evaluation Services, if needed.

Biopsychosocial Assessment and Evaluation Services

BBHC will provide all biopsychosocial assessment and evaluation services through the selected network service provider, based on the specific needs identified for the student. Assessments must be conducted by a licensed or clinicians or by a clinician under the supervision of a licensed clinician, based on BBHC's policy. Assessments and evaluations must be completed within fifteen (15) calendar days of receipt of the referral from the SBBC. Assessment reports must include the provider's recommendation of services required, which will be shared with the student, their family, and the student's school/referral source.

Continued Care Coordination and Continued Behavioral Health Services

BBHC's Care Coordinator will manage all referrals following completion of the assessment, coordinate any continued care needs, and continue to work with the student and family to facilitate access to the services recommended. Enrollment for these services must occur within thirty (30) calendar days from completing the assessment or evaluation. Behavioral health services rendered must be billed based on BBHC's rates when the student or their family does not have insurance coverage through Medicaid or private insurance. Network providers must complete quarterly reports

on the progress of students being served and participate in staffings for students, as necessary.

Covered Services and Rates Per Hour

See below the covered services allowed through this program. The rates will be aligned with BBHC's rates.. The rates will be an attachment to each year's contract/agreement. Each rate will have its specific time allowed, for example, with assessments the rate is per hour.

1. Assessment
2. Case Management
3. Day Treatment
4. Incidental Expenses
5. In-home and On-site
6. Medical Services
7. Outpatient Group
8. Outpatient Individual
9. Recovery Support Group
10. Recovery Support Individual
11. Supported Employment/Education
12. Supportive Housing/Living

BBHC or its network providers may recommend additional behavioral health services such as family counseling, multidisciplinary team treatment, and treatment planning. Providers will participate in BBHC meetings regarding the SBHSP, as necessary.

Provider will only invoice BBHC for services when the student does not have Medicaid or private insurance, and in the case where Medicaid or their insurance does not cover the specific service provided. BBHC will also allow invoicing for service denied by Medicaid or other insurance as long as it is supported by clinical documentation justifying a continued need for service. Furthermore, BBHC will allow invoicing when Medicaid or other insurance coverage has been exhausted. All the supporting documentation for these cases must be maintained in the students' files for potential audit.

Programmatic Forms
All forms will be found on the BBHC Online Portal.

1. **Referral Form**
2. **Screening & Assessment Form**
3. **Enrollment Admission Notice**
4. **Quarterly Progress Report**
5. **Discharge Form**

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XXVII. Family Connections Through Peer Recovery (Family-CPR) Project

A five-year Federal research grant awarded to Broward Behavioral Health Coalition (BBHC) in full partnership with ChildNet, as well as other community stakeholders. The goal of the program is to demonstrate that the early identification, the use of a specifically developed intervention including peer support, ongoing follow-up, and a closely coordinated team approach over a longer period of time can change outcomes. This project is family centered and child focused, with the goal of keeping children safe at home.
The key principles of the grant are:

1. An integrated continuum of care
2. Intensive family engagement
3. Peer Support

In order to support the key principles of the Family CPR Project, BBHC is asking Providers to participate in a taskforce that will develop a network wide policy regarding HIPAA and coordination of care across Providers. Specific taskforce information will be communicated to Providers via email.

As the grant is moving towards closure it has been modified to ensure sustainability.

THE PROJECT GOALS:

1. Increased parental retention in treatment
2. Enhanced provision of targeted services for children and caregivers/parents
3. Improved parenting practices
4. Decrease in family trauma

The ultimate aim is to enhance child and family well-being and reduce incidences of re-abuse, child welfare re-referrals and removals.

TARGET POPULATION

1. Families with parental substances use disorders who are referred to ChildNet for dependency case management.
2. Children ages 0-11 years, and who have been determined to be unsafe and will receive Non-Judicial or Judicial In-home Case Management.

FAMILY-CPR TEAM MEMBERS

1. Three Child Advocates/Family Care Coordinators
2. Three Peers
3. One ChildNet Supervisor
4. Project Director
5. Child Welfare/Behavioral Health Care Coordinator

ENGAGING CAREGIVERS/PARENTS PROGRAM

The Intervention: Family CPR Approach

1. Phase 1: Motivation and Rapport Phase (1 month average)
2. Phase 2: Intervention Phase (2-4 months average)
3. Phase 3: Transition to Natural Supports (Month 5-7 average)
4. Aftercare up 6 months

XXVIII. Power of Peers (POP)

The original POP Pilot Project was implemented based on the fact that individuals being discharged from South Florida State Hospital face many challenges. It was acknowledged that the first thirty (30) days from discharge are critical in terms of the person's successful transition to the community.

In an effort to assist with this transition, a pool of certified Peer Specialists was identified to best match the person being discharged in terms of age, sex, culture, and other factors. They began to visit the hospital resident within 30 days of discharge and develop a relationship with them. On the day of discharge, the peer meets them at their new "home" wherever that is (ALF, residential program, family home, SRO, etc.) and helps them acclimate to their new surroundings. They continue to assist the individual with whatever they need, link them to a drop-in center as appropriate or other support services, work with them to develop a WRAP Plan, and other activities of the person's choosing. Together the peer and the person served would decide how often and how long the connection would remain. This Peer Specialist becomes a "natural support" and can make a difference in how well the person succeeds in the community.

It is important that the Peer Specialists work under a licensed clinician to insure if there are any serious issues that arise, they can be addressed professionally and swiftly, particularly if clinical intervention is indicated. Regular supervision meetings are required so case issues are addressed and also to make sure that the peers are receiving clinical oversight for their own well-being.

Based on the success of this pilot program, it has been expanded to include those Baker Act receiving facilities and detoxification units funded by Broward Behavioral Health Coalition. It is anticipated that inclusion of these facilities and linkage to peers in recovery, will result in a reduction of readmissions for Baker Acts and/or detoxification.
During the course of their contacts, the Peer Specialists would also have contact with the facility staff and the case manager, if applicable to ensure communication is maintained.

Requirements of the Peer Specialists providing services:

1. Complete WRAP (Wellness Recovery Action Plan) Training within 6- months of hire.
2. Complete Peer Specialist Training to obtain certification through the Florida Certification Board within eighteen (18) months year of hire.

Following are some of the activities to be tracked:

1. Number of contacts on a weekly basis
2. Identify linkage to services/activities
3. Requests of the person discharged
4. Clinical intervention referrals
5. Supervision activities with the licensed clinician
6. Others to be determined
7. All peers funded for the Power of Peers Program are required to attend 90% of all scheduled Power of Peers Meetings set by BBHC Transition to Independence (TIP)

Guidance: Florida Department of Children and Families Substance Abuse and Mental Health Program (DCF-SAMH): Florida Peer Services Guidance Handbook
https://www.myflfamilies.com/service-programs/samh/publications/docs/peer-services/DCF-Peer-Guidance.pdf

XXIX. Transitional to Independence Process (TIP) Broward TIP Collaborative

THE BROWARD TIP COLLABORATIVE was developed in 2016 as a result of the expansion of TIP services across funders in Broward County (County, BBHC, CSC). This Collaborative provides a venue for peer-to-peer learning, ongoing coaching, and implementation guidance for professionals who are committed to implement the TIP Model for transition-aged youth experiencing mental health and co-occurring issues. Participating providers will learn to do the TIP Model with a high degree of skill and fidelity. Transition Facilitators (i.e., Wellness Coaches or other similar job title) will improve their ability to engage youth and emerging adults through relationship development and TIP core practices. The Collaborative will meet quarterly to provide support for agencies.

TIP Fidelity Reviews

TIP providers must participate in the TIP Model Fidelity QI Process when notified of a fidelity review by BBHC staff. Providers who pass all areas of the TIP fidelity review will not need a new review until 3 years later. Those providers who do not pass all areas of the fidelity reviews will need a follow-up review within 9-12 months to ensure continued improvement.

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XXX. One Community Partnership 3 (OCP3)

One Community Partnership 3 (OCP3) is a Broward youth system of care grant awarded through the Substance Abuse and Mental Health Services Administration (SAMHSA) to Broward County. The overarching purpose of OCP3 is to enhance infrastructure and build evidence-based mental health service capacity within the Broward School and Child Welfare for young people between the ages of 12 and 21 years old with serious emotional disturbance (SED) and those with early signs and symptoms of serious mental illness (SMI). OCP3 will serve 18 youth in year one, 65 youth in year two, 58 youth in year three, and 59 youth in year four, with a total of 200 unduplicated youth and their families (biological/foster) served throughout the grant.

This initiative ensures that youth and emerging adults who experience difficulties due to mental health and co-occurring issues receive effective, evidence-supported services to successfully transition into adulthood. This initiative is facilitating Broward's System of Care implementation of effective transitional supports for emerging adults on their way towards resiliency, recovery, and wellness.

Available Services

In an effort to inflict cultural transformation within both the school and child welfare systems through establishing evidence-based (EB) service capacity using strength-based, recovery-oriented and youth and family-focused models, Broward County Public Schools (BCPS)Social Workers/Counselors and ChildNet Case Managers/Child Advocates will be trained in both the Transition to Independence (TIP) Model and Wraparound approach. TIP and Wraparound trained staff will refer youth/emerging adults as applicable to the OCP3 program for linkage to community-based services and will remain a part of the youth's treatment team.

Transition to Independence Process (TIP) Model

The **Transition to Independence Process (TIP) Model** was developed for working with youth and young adults with emotional/behavioral difficulties. Within OCP3, the TIP Model is one of the core services approaches for transition-aged youth (14 – 21 years old). Services focus on helping each youth identify and solidify a natural support system to sustain recovery. TIP is recognized as an age-appropriate, community-based model for emerging adults with SMI. This youth-driven approach emphasizes youth voice/choice and facilitates independence and self-determination by empowering youth to lead their own Futures Planning process while ensuring services and supports meet them where they are. TIP will be provided by a local team of certified Regional Site-Based trainers.

Wraparound

The **Wraparound approach** is a comprehensive, holistic, family-driven way of responding to the youth's mental health and behavioral challenges. OCP3 youth aged 12 - 13 and their families receive support from, and are at the center of, a team of professionals and natural supports, with the youth's and family's ideas and perspectives driving service planning. Wraparound training will be provided BBHC's workforce.

Moral Reconation Therapy (MRT) is an evidence-based cognitive-behavioral model that leads to enhanced moral reasoning, better decision making, decreased disciplinary infractions, and beneficial changes to personality traits.

In addition to expanding evidence-based service capacity, OCP3 creates cross-systems care coordination policies to bridge the school and Broward County Public Schools and ChildNet workforces with System of Care recovery support services.

Served youth and families also have access to a comprehensive continuum of services that are currently available and funded by the Broward County Human Services Division, Broward Behavioral Health Coalition, and the Children's Services Council of Broward that includes:

- Diagnostic Assessment & Evaluation Utilizing The GAIN-SS Assessment and Full Mental Health Assessments,
- 24/7 Emergency Crisis Stabilization and 24/7 Youth and Adult Mobile Crisis Teams,
- Outpatient Services (Including Group and Family Treatment), Youth Peer Support via **Youth M.O.V.E. Broward Chapter**,
- Parent/Caregiver Peer Support via the **Federation of Families Broward Chapter**,
- Substance Abuse and Co-Occurring Treatment (Detox, Residential, Day Treatment, Outpatient),
- Intensive Day Treatment,
- Intensive Home and Community-Based Services and Multidisciplinary Teams (**Community Action Treatment (CAT) Team, First-Episode Psychosis Team (FEPT)**)
- Psychotropic Medication Management,
- Community Case Management and Recovery Support,
- Clubhouse and Drop-In Center Services Including the **Flite Center – Youth Drop-In Center**,
- Therapeutic Foster Care/Family/Group Home,
- Trauma-Focused and Trauma-Resolution Therapy Including TF-CBT, TREM, Seeking Safety, and Traumatic Incident Reduction (TIR),
- Supported Housing Using **Housing First** EBP,
- Supported Employment Using **Individual Placement and Support (IPS)** EBP.

REFERRAL & ENROLLMENT PROCESS

Youth can be identified as a good fit for OCP3 participation by another young person, teacher, school social worker, parent/caregiver, case manager, child advocate, and/or administrator. Once the youth has been identified, a TIP/Wraparound trained school social worker or child advocate will engage the youth in two to three contacts to get to know the youth, determine eligibility, establish rapport, introduce OCP3, and gauge interest in program participation. The staff member would then complete the OCP3 Referral Form via Cognito link, to include uploading appropriate mental health documentation and consent forms.

The Clinical Integration Coordinator (CIC) will receive all referrals, determine eligibility for inclusion in OCP3, and notify all interested parties of said decision through a Disposition Notice. If the youth is not accepted into OCP3, the referral source will be provided suggestions on alternative resources for a secondary referral. If the youth is accepted into the program, the CIC will assign the youth to an approved OCP3 TIP/Wraparound provider.

The provider must assign a TIP/Wraparound Facilitator who will then contact the referral source to initiate the Hot Handoff (HH) with the youth. Following the completion of any provider-specific intake paperwork, details of the HH are documented and submitted by the TIP/Wraparound Facilitator via the OCP3 Enrollment Notice within 48 hours of youth enrollment into services. During the intake session, the facilitator will also introduce the youth to the OCP3 Evaluation Program and offer an opportunity for the youth to sign the Consent to Contact form via Cognito link, allowing a BBHC Peer Evaluator to contact them to provide additional information.

Forms for OCP3 services can be accessed through this link: http://ocp3.org/servicesforms/

OCP3 EVALUATION PROGRAM

Youth served and their families will have the opportunity to provide feedback about services by participating and enrolling in the OCP3 Evaluation Program. Incentives are provided for their time and participation. BBHC Peer Evaluators will meet with youth who agree to participate and ask about the effectiveness and satisfaction of services. Youth and family participation in the evaluation is fully voluntary and based on informed consent. OCP3 staff will provide training as well as information about the evaluation that participating agencies can share with youth and families. Agencies participating in the OCP3 program agree to collaborate with the voluntary Evaluation process.

Benefits of Participation

- Tracking of progress and recovery outcomes for youth and young adults with emotional/behavioral difficulties (EBD).
- Feedback about TIP Model and Wraparound approach competency informing targeted technical assistance.
- Enhanced staff and supervisor competencies for working with youth and their families
- Development of high-fidelity TIP and Wraparound through participation in fidelity evaluation and technical assistance for the agency.

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XXXI. Supported Employment/ Individual Placement and (IPS)

Individual Placement and Support (IPS) is a model of supported employment/education designed for people with serious mental illness. IPS supported employment helps people living with behavioral health conditions work at regular jobs of their choosing. Although variations of supported employment exist, IPS refers to the evidence-based practice of supported employment. IPS includes mainstream education and technical training as ways to advance career paths. IPS relies on the following principles:

- Zero exclusion
- Competitive employment
- Rapid job search
- Systematic job development
- Integrated Services
- Benefits Planning
- Time unlimited supports
- Worker preferences

Providers must provide services to transition-age youth from TIP providers as part of the OCP3 initiative if applicable. Organizations providing IPS services must meet fidelity by adhering to the Supported Employment Fidelity Scale found on the https://ipsworks.org website. Providers agree to attend relevant OCP3 committees, participate in monthly consultation sessions with
BBHC staff and participate in training as scheduled. Providers must enter all services into the portal using the Supported Employment code.
IPS Team:
Providers will develop a supported employment team comprised of:

1 IPS Supervisor per 10 employment specialists:

- Provides oversight to the IPS supported employment program. Ensures good program outcomes through training, supervision, and field mentoring. Attempts to meet most people who receive IPS services. Monitors outcomes and implements quality improvement plans.
- Acts as a liaison to other departments and agencies. The supervisor provides supervision to no more than ten employment specialists. Provides IPS supported employment services for a caseload of no more than eight people (only if there are no supervisory duties outside of IPS).

2 Employment Specialists:

- Provides all phases of employment services to a caseload of no more than 20 individuals, including intake, engagement, assessment, job placement, job coaching, and follow-along support to assist clients in obtaining and maintaining employment that is consistent with their vocational goals.
- Vocational Peer (optional): assist persons served in developing coping and problem-solving strategies for illness self-management before and doing employment; draw on lived experiences and empathy to promote hope, insights, and skills; help engage in treatment and employment/educational plans, and access community supports.

Referral Process for Providers Providing IPS Services Externally:

Providers that are serving individuals externally within BBHC's provider network ensure that the referral source completes the following forms in Cognito: referral forms, the extension for service request forms for the continuation of services, and discharge forms.

IPS Data Reporting:
IPS rosters must be submitted monthly to BBHC by the 5th of every month. IPS providers registered with the National IPS Center's web portal must enter IPS data by the 10th quarterly.

IPS Training and Technical Assistance:
Providers are required to attend all training and meetings and ensure that any new staff take the IPS supervisor or practitioner skills online course on the www.IPSWorks.org website, and submit monthly rosters, monthly caseload report, and any annual reports as requested from BBHC.
Providers will develop their own internal IPS Steering Committee, which consists of the IPS team, leadership staff, and community stakeholders (e.g., other community providers and community employers) to help plan and monitor IPS Supported Employment implementation and sustainment. BBHC will participate in each organization's steering committee as per toolkit implementation recommendations to ensure collaboration and sustainability. IPS Supervisors and a representative from IPS provider agencies are required to attend BBHC's quarterly IPS Learning Community meetings.

Visit the IPS Center's website www.IPSworks.org for more information about the steering committee.

Vocational Rehabilitation Contract:
All IPS Providers must submit an application to the Vocational Rehabilitation for a supported employment contract within the first six months of implementing the IPS model to maximize funding for necessary employment services (e.g., school tuition payment, dental services, books).

IPS Fidelity Reviews:
Providers are to coordinate a fidelity visit with BBHC's IPS designated fidelity reviewers for their baseline review after six-months of implementation. The fidelity reviewers will utilize the IPS 25-item quality improvement tool (refer to the IPS Center's fidelity scale) to assess the IPS program's performance. Providers need to achieve a Fair Fidelity score after six-months of implementation. The fidelity reviewers will provide a finalized report with the results 60-days after the initial fidelity visit. Providers who achieve Fair Fidelity will continue to be annually assessed (as applicable) by BBHC's fidelity reviewers and must maintain a Good Fidelity score after the first annual fidelity review. Providers who fail to score Fair Fidelity on their baseline review will undergo another six-month fidelity assessment to measure the quality of improvement. Providers are required to adhere to the IPS program's fidelity via the fidelity scale found at www.IPSWorks.org, adhere to the Continuous Quality Improvement and Program Evaluation Process.

IPS Outcomes/Indicators:
BBHC's clients will receive individualized IPS services (job coaching, interview skills, and resume preparation). IPS providers must meet the following outcomes:

- 75% of people served for a minimum of 30 days will receive an individual career profile
- 65% of people served will have secure employment at the time of discharge from the IPS program

- 75% of program graduates will remain gainfully employed for at least one month after discharge from services
- Providers delivering IPS services will maintain a minimum annual competitive employment rate of 55 % -75%.

Other Supported Employment

Providers receiving funding for supported employment services must submit all reports requested by DCF to BBHC on the 10th of the month following the reporting period unless otherwise specified. BBHC may ask for revisions to reports, and providers are responsible for resubmitting all reports after correction.

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XXXII. Supportive Housing (PSH)

The BBHC-funded Supported Housing (SH) program was created in 2016 to expand independent living opportunities in the community for persons served within the Substance Abuse and Mental Health (SAMH) System of Care in Broward, who otherwise may be limited to housing placement in a congregate living arrangement, discharging to homelessness, or dependent living without the option to reintegrate into the community. Offering the resources and supports to obtain and retain participant-chosen independent living opportunities with full tenancy rights, paired with community-based services determined by the participant are supported by the service providers across multiple systems of care.

Adults, ages 18 years old and above, who have a mental health and/or co-occurring diagnosis can and meet the target population's admission criteria may be referred to both Archways and Henderson Behavioral Health for placement in a BBHC-funded SH program. Currently, BBHC provides funding to support 10 participants in Archways' SH program and 83 participants in Henderson Behavioral Health's SH program. The Henderson SH program includes funding to support 33 OCP3-enrolled young adults, in their SH program. Henderson Behavioral Health maintains the role of the housing provider and the TIP providers maintain the responsibility of providing participant-driven supportive services to assist with housing retention and the participant's wellness and recovery for those that are enrolled in the young adult program. There is also funding for 50 adult participants within the 83 total available spots.

Referrals for both Archways and Henderson Behavioral Health can be submitted by both inter-agency service providers and outside-agency service providers within the community.

Organizations providing SH services must meet fidelity by adhering to the Permanent Supportive Housing Evidence-Based Practices (EBP) KIT fidelity scale on SAMHSA website.

Providers agree to attend relevant OCP3 committees, participate in monthly consultation session with BBHC staff, provide rosters on clients served as requested, and participate in TIP Solutions Review calls as scheduled. All services must be entered into the Carisk Partners portal using the Supportive Housing Code.

TARGETED POPULATION(S):

- Individuals who do not meet the Federal HUD Definition of Homeless, Category 1 (Literally homeless) or Category 4 (Currently fleeing domestic violence); and are therefore not eligible for Homeless Continuum of Care assistance.
- Individuals who are exiting a Residential Treatment Facility and who lack the resources and supports necessary to obtain housing in the community.
- Individuals who are currently residing in a Recovery Residence.
- Individuals who are housing insecure or have not maintained a lease in their own name within the last 60 days and lack the resources and supports to secure a lease in their own name.
- Individuals who are at-risk of homelessness.

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XXXIII. BBHC Housing Initiative

BBHC began implementing its Housing Initiative as part of a state requirement from DCF for all Managing Entities, hence all BBHC housing program will abide by Guidance 21 - Housing Coordination.

Mission: to address accessibility, sustainability, and wrap-around supports for persons with mental illness and substance use issues who are homeless, at-risk of homelessness or are exiting institutional care and need on-going supports to live independently.

Purpose:

- Increase and improve collaboration and coordination with COC, Florida Housing Finance Corporation (FHFC), and other key state and local agencies as they relate to housing-related services;
- Find safe, affordable, stable housing for individuals with mental health and/or co-occurring diagnoses;
- Ensure that these individuals receive the necessary support services to be successful in the community; and
- Increase the number of discharges from state mental health treatment facilities to stable community housing in lieu of discharges to community crisis stabilization units, to addiction receiving facilities, or to placements increasing the risk of subsequent homelessness.

PROVIDER REQUIREMENTS:

- Only Hospitals, CSUs, CRSs and Detox Providers are currently required to submit referrals per initiative requirements; training is being provided to eligible RTFs for further expansion.
- Providers must ensure that all eligible clients are screened upon intake and the policies below are followed.
- Referrals are only accepted from BBHC-trained staff who maintain familiarity with the Behavioral Healthcare & CoC Homeless Housing Systems Integration process, HUD Homeless Definitions, and utilization of the VI-SPDAT ("Vulnerability Index- Service Prioritization Decision Assistance Tool") Training - Single Adult, Youth, and Family.

Referral Process

1. Referrals must be sent to BBHC within 24 hours of completing the housing referral packet:
    a. Faxed to BBHC at 954-332-1476
    b. Encrypted e-mail to: housing@bbhcflorida.org
    c. Via Cognito Forms Link: https://www.cognitoforms.com/BrowardBehavioralHealthCoalition/housingreferraleligibilitychecklist2
2. The Housing/SOAR Entitlements Coordinator will enter the data into HMIS within 48 hours of receiving the referral.
3. The Housing/SOAR Entitlements Coordinator will provide the referring agency with a confirmation e-mail detailing that the applicant is entered into HMIS.
4. Individuals that do not meet **both** the HUD definition of homeless *and* behavioral health criteria are not to be referred.
5. Only individuals who meet the criteria for Categories 1 or 4 of HUD's definition of homeless will be entered into the CoC's HMIS system.
6. Incomplete referral packets will not be accepted.

BBHC's ROLE: Through this initiative, BBHC has hired a Housing and SOAR/Entitlements Coordinator to support implementation and technical assistance for the network. The Housing and SOAR Entitlements Coordinator will:

1. Evaluate applications, confirming eligibility according to HUD's definition of homeless categories.
2. Refer to SOAR Coordinator if individual meets criteria for further SOAR screening.
3. Search for referred applicant in HMIS prior to entering data, ensuring no duplication.
4. Verify documentation of homeless history in HMIS.
5. Enter applicant data into HMIS, initiating referral to the CoC for individuals who meet Category 1 or Category 4 of HUD homeless definition.
6. Track applicants who meet Category 2 or Category 3 of HUD homeless definitions in an internal BBHC database.
7. Refer Category 2 and 3 individuals to agencies that provide homeless prevention funding and services.
8. Track applicant through treatment, advising discharge planner or social worker of 80, 60 and 30-day time limitations prior to discharge from institutional care facility
    - Ensure length of stay does not exceed 89 days, unless medically necessary.
9. Link applicant to primary behavioral health case manager during stay at institutional care facility.
10. Communicate status of applicant to CoC's Chronic Workgroup, providing updates throughout duration of care
11. Comply with HUD's recordkeeping requirements by utilizing BBHC's data management system to document admission to and discharge from care facility in HMIS
12. Investigate homeless episode prior to facility entry (i.e.: police records, outreach, etc.)
13. Provide follow-up six months and one-year after exiting facility

Please refer to the Housing Manual on the BBHC website for full details. https://bbhcflorida.org/housing-initiative/

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XXXIV. Short- Term Respite Program (Substance Use or Co-Occurring)

Purpose: Short- Term Respite Program is designated for Substance Use or Co-Occurring individuals:

1) who have relapsed on substances and need a safe place to stay for a short time;
2) those who require a short gap for transitional or residential treatment facility (RTF/ALF) placement;
3) are in transit to court ordered program **and** the designated aftercare location is already identified.

Capacity: Minimum 20 beds

Duration: 0-14 days. Anticipated length of stay is 72 hours per individual. Extended stay may be approved on an individual basis.

Exclusions: No one in a medical crisis, all individuals must be able to manage their ADL's independently.

Procedure:

1. The referring BBHC Network Provider must submit the Short-Term Respite form using the Cognito link below:

Fellowship:
https://www.cognitoforms.com/BrowardBehavioralHealthCoalition/bbhcrespitebedrequestapprovalform

- Call phone number 754-757-9147
- 24hours a day to complete required phone assessment.

Project Soar:
https://www.cognitoforms.com/BrowardBehavioralHealthCoalition/bbhcprojectsoarrespitebedrequestapprovalform

- Contact 954-817-1685 to complete the required phone assessment.

Note: The aftercare location verification must be uploaded to the request form.

Verification of the Aftercare Plan Include:

- **Residential Treatment Facility (RTF)-** authorization uploaded with admission date.
- **FARR Recovery Residence-** email verifying eligibility to Return or Admission date.
- **Assisted Living Facility-** email verifying eligibility to Return or Admission date.
- **Family/Friend-** email verification with date to return to family/friend and contact information.

2. BBHC will provide disposition to request and send back to the referring BBHC Network Provider within 48 business hours or less. If the request is approved, The Provider will be copied on the email. The referring BBHC Network Provider is responsible for bringing the BBHC Approval Authorization with the individual upon admission.

Program Expectations:

Individuals who are accepted into the Respite are given the opportunity to stay in a safe and sober

housing environment; to continue working on their recovery program, they will be provided with Peer Recovery Support Services (PRSS). The peers provide emotional, informational, instrumental support, to include but not limited to: peer mentoring and peer-led support groups. Job information sharing, connecting clients with social health services and other resources, recovery navigational support, life skills workshops and much more. Individuals are expected to be engaged in the daily activities at the respite, which will continue to evolve as the population grows.

- Once at the respite, belongings will be safe-guarded and only necessities will be permitted, to include extra clothing, recovery literature, etc.
- Individuals should only leave the property with a verified scheduled appointment and with accompaniment, unless coordinated with notice.
- Cellphones will not be permitted. Individuals will be able to make a short phone call at scheduled times.
- If the person has prescribed medication, Respite staff will store the medication in the designated secured/locked location and provide medication oversight with documentation.
- Urinalysis and Breathalyzer will be performed upon intake and documented.
- Respite Staff member will complete the basic intake packet with the individual.
- Provider staff must accompany individual to any appointments outside of the Respite Program while residing on the premises.
- Breakfast, sandwich lunch, and dinner is provided.

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XXXV. MH Respite Services Program Summary

Mental Health Respite Housing is designated for individuals living with a Mental Health/or Substance Use diagnosis and:

- Who are being discharged from an Acute Care Unit, CSU or Residential Program that need a safe place to stay for a short period of time. Have relapsed on substances and need a safe place to stay for a short time.
- Require a short gap for transitional or residential treatment facility (RTF/ALF) placement and/or;
- Are in transit to a court ordered program **and** the designated aftercare location is already identified.

Exclusions: No one in a medical crisis. All individuals must be able to manage their ADL's independently.

SCOPE OF SERVICES

- The Respite Housing can provide short-term respite services for up to 30 days, contingent on BBHC authorization. The anticipated length of stay is 30 days, per individual. Extended stay may be approved on a case-by-case basis. Individuals will be provided with three meals per day, linens (bedding and towels), laundry facilities, and hygiene products.
- The Respite Housing providers will participate in BBHC trainings to best serve participants in the BBHC network.
- The Respite Housing providers will submit daily census to BBHC's Housing Coordinator or designated BBHC staff.
- The Respite Housing Providers will provide oversight and support for community services. There will be access to Peer Recovery Support Services (PRSS). The peers provide emotional, informational, instrumental support, to include but not limited to the following: peer mentoring, peer-led support groups, job information sharing, connecting clients with social health services and other resources, recovery navigational support, life skills and much more.

PROCEDURE

- The Network Provider submits the Respite Request using the Cognito link and it will electronically be sent to the designated BBHC Housing Coordinator for review.
  Cognito Link- Homes United:
  https://www.cognitoforms.com/BrowardBehavioralHealthCoalition/bbhchomesunitedmentalhealthrespiteform

The aftercare location verification must be identified in the request.

Verification of the Aftercare Plan include:

- **Residential Treatment Facility (RTF)**: Anticipated date of admission
- **FARR Recovery Residence**: E-mail verifying eligibility to Return or Admission date
- **Assisted Living Facility**: E-mail verifying eligibility to Return or Admission date
- **Family/Friend**: Email verification with date of return to family/friend and contact information for the individual.

BBHC will provide disposition to request and send back to the referring BBHC Network Provider within 48 business hours or less. If the request is approved, the Respite Provider will be copied on the e-mail. The referring BBHC Network Provider is responsible for bringing the BBHC Approval Authorization with the individual upon admission.

The Respite Provider will submit a daily census to support the admission disposition process to: wking@bbhcflorida.org or designated BBHC staff.

The Respite Provider will submit the monthly invoice to wking@bbhcflorida.org or designated BBHC staff by the 5th of the following month for processing. BBHC will manage the census for the Respite Housing Program.

EXPECTATIONS

- Clients are expected to be engaged in the daily activities at the respite, which will continue to evolve as the population grows.
- Once at the respite, clients' belongings will be searched and only necessities will be permitted (include extra clothing, recovery literature, etc.)
- Respite Staff members will complete the basic intake packet with client.
- Breakfast, sandwich lunch, and dinner will be provided.
- Clients will not be permitted to leave the property.
- Cellphones will not be permitted without authorization from the Respite housing providers.
- Clients will be able to make a short phone call at scheduled times.
- If client has prescribed medication, Respite staff will provide locked storage and store the medication in the designated secured/locked location and provide medication oversight with tracking documentation.
- While clients are residing in the respite housing program, BBHC Network Providers must accompany and/or assist in coordination for individuals to any appointments outside of the Respite Program.

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XXXVI. Transitional Housing Program Summary

The Mental Health Transitional Housing Program is designated for housing homeless individuals who:

- Are living with Mental Health Diagnosis and/or a co-occurring diagnosis.
- May need a safe place to stay while transitioning to community living.
- Require a short gap of housing funding to continue the pathway to Treatment allowing the individual to become independently financially self-sufficient.

Exclusions: No one in a medical crisis. All individuals must be able to manage their ADL's **independently.**

Scope of Services:

Transitional housing may assist individuals for 1 to 6 months or longer based on a case-by-case basis and is contingent upon BBHC authorization. The anticipated length of funding is 1 to 6 months, per individual. Extended stay may be approved on a case-by-case basis.

1. Individuals will be provided with technology, if needed, to participate in substance use/ or Mental Health Treatment per their community treatment provider and aftercare plan. Assistance may include: an office or designated area with a computer to participate in therapeutic groups, individual therapy or other appointments.
2. A Food pantry, and assistance with linens (bedding and towels), laundry facilities, and hygiene products, if needed.
3. The Transitional Housing Providers will participate in BBHC trainings to best serve participants in Transitional Housing Program.
4. The Transitional Housing providers will provide a monthly census to BBHC's Housing Coordinator or designated BBHC staff.
5. The Transitional Housing providers will provide access to Peer Recovery Support Services (PRSS). The peers provide emotional, informational, instrumental support, to include but not limited to the following: peer mentoring, peer-led support groups, job information sharing, connecting clients with social health services and other resources, recovery navigational support, life skills workshops and much more.

PROCEDURE

The Network Provider will submit the Transitional Housing Request using the Cognito link below and it will electronically be sent to the designated BBHC Housing Coordinator or designated staff for review.

Cognito Links:

Homes United:
https://www.cognitoforms.com/BrowardBehavioralHealthCoalition/bbhchomesunitedtransitionalhousingform

Adult Residential Communities (ARC):
https://www.cognitoforms.com/BrowardBehavioralHealthCoalition/bbhcadultresidentialcommunitiesarctransitionalhousingform

The aftercare location verification must be identified in the request. Verification of the Aftercare Plan include:

The treatment provider and services for the individual to continue Substance Use/Mental Health Treatment.

- **Residential Treatment Facility (RTF)**: Anticipated date of admission
- **FARR Recovery Residence**: E-mail verifying eligibility to Return or Admission date
- **Assisted Living Facility**: E-mail verifying eligibility to Return or Admission date
- **Family/Friend**: Email verification with date of return to family/friend and contact information for the individual.

2. BBHC will provide disposition to request and send back to the referring BBHC Network Provider within 48 business hours or less. If the request is approved, The Transitional Housing Providers will be copied on the e-mail. The referring BBHC Network Provider is responsible for bringing the BBHC Approval Authorization with the individual upon admission.

The Transitional Housing Provider will submit a daily census to support the admission disposition process to: wking@bbhcflorida.org or designated BBHC staff.

3. The Transitional Housing Provider will submit the monthly invoice to wking@bbhcflorida.org or designated BBHC staff by the 5th of the following month for processing or provide a copy of the invoice to the appropriate network provider for processing depending on agreements. BBHC will manage the census for the Transitional Housing Program.

EXPECTATIONS

A. Clients are expected to be engaged in the daily activities while residing in Transitional Housing.
B. The Transitional Housing clients' belongings maybe searched and only necessities will be permitted (include extra clothing, recovery literature, etc.)
C. The Transitional Housing Staff members will complete the basic intake packet with client.
D. Food and other necessities are the responsibility of the individual. However, needs may be assessed and coordinated by the Transitional Housing providers and network providers on a case-by-case basis.
E. Clients will be able to participate in their treatment, including access to a computer to participate in the virtual groups, individual therapy, or other appointments, if needed.
F. While clients are residing in the Transitional Housing program, BBHC Network Providers must identify the treatment appointments designated for the individual.

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XXXVII. BBHC Care Coordination

BBHC began implementing the Care Coordination Program as part of a state requirement from DCF for all Managing Entities and will abide by Guidance 4- Care Coordination.

PURPOSE AND GOALS

Care Coordination serves to assist individuals who are not effectively connected with the services and supports they need to transition successfully from higher levels of care to effective community-based care. This includes services and supports that affect a person's overall well-being, such as primary physical health care, housing, and social connectedness. Care Coordination connects systems including behavioral health, primary care, peer and natural supports, housing, education, vocation and the justice systems. It is time-limited, with a heavy concentration on educating and empowering the person served and provides a single point of contact until a person is adequately connected to the care that meets their needs.

The short-term goals of implementing Care Coordination are to:

- Improve transitions from acute and restrictive to less restrictive community-based levels of care;
- Increase diversions from state mental health treatment facility admissions;
- Decrease avoidable hospitalizations, inpatient care, incarcerations, and homelessness; and
- Focus on an individual's wellness and community integration.

The long-term goals of implementing Care Coordination are to:

- Shift from an acute care model of care to a recovery model; and
- Offer an array of services and supports to meet an individual's chosen pathway to recovery.

PRIORITY POPULATIONS

Pursuant to s. 394.9082(3)(c), F.S., the Department has defined several priority populations to potentially benefit from Care Coordination. Managing Entities and provider agencies are expected to utilize at least 50% of allocated funds in OCAs MH0CN and MS0CN to serve the following populations.

1. Adults with a serious mental illness (SMI), substance use disorder (SUD), or co-occurring disorders who demonstrate high utilization of acute care services, including crisis stabilization, inpatient, and inpatient detoxification services. For the purposes of this document, high utilization is defined as:

    a. Adults with three (3) or more acute care admissions within 180 days, or

    b. Adults with acute care admissions that last 16 days or longer, or

    c. Adults with three (3) or more evaluations at an acute care facility within 180 days, regardless of admission.

2. Adults with a SMI awaiting placement in a state mental health treatment facility (SMHTF) or awaiting discharge from a SMHTF back to the community.

The Department has defined additional populations to benefit from Care Coordination using funds in OCAs MHCAS and MSCAS.

Under OCA MHCAS:

1. Children and parents or caretakers in the child welfare system with behavioral health needs, including adolescents, as defined in s. 394.492, who require assistance in transitioning to services provided in 4 the adult system of care.

2. Children and adolescents with a mental health diagnosis, SUD, or co-occurring disorders who demonstrate high utilization. For the purposes of this document, high utilization is defined as: children and adolescents under 18 years of age with three (3) or more admissions into a crisis stabilization unit or an inpatient psychiatric hospital within 180 days, including:

a. Children being discharged from Baker Act Receiving Facilities, Emergency Rooms, jails, or juvenile justice facilities at least one time, who are at risk of re-entry into these institutions or of high utilization for crisis stabilization.

b. Children and adolescents who have recently resided in, or are currently awaiting admission to or discharge from, a treatment facility for children and adolescents as defined in s. 394.455, which includes facilities (hospital, community facility, public or private facility, or receiving or treatment facility) and residential facilities for mental health, or co-occurring disorders.

3. Children not currently receiving services by a CAT Team.

Under OCA MSCAS:

1. Families with infants experiencing or at risk for Neonatal Abstinence Syndrome or Substance Exposed Newborn.

The following populations may receive Care Coordination from the remaining balance of OCAs MS0CN and MH0CN allocated funds with Department Regional Office approval.

1. Persons with a SED, SMI, SUD, or co-occurring disorders who are involved with the criminal justice system, including: a history of multiple arrests, involuntary placements, or violations of parole leading to institutionalization or incarceration.

2. Caretakers and parents with an SMI, SUD, or co-occurring disorders considered at risk for involvement with child welfare.

3. Individuals identified by the Department, Managing Entities, or Network Service Providers as potentially high risk due to concerns that warrant Care Coordination.

Care Coordination under these OCAs cannot be provided to individuals enrolled in the following team-based services FACT, Coordinated Specialty Care for Early Mental Illness, CAT, FIT, Comprehensive Community Service Teams, Forensic Multidisciplinary Teams, and any other local multidisciplinary treatment teams that include case management.

If necessary, Managing Entities and Network Service Providers may implement a time-limited transition plan for individuals in the process of connecting to a case manager or team-based services that includes case managers (excluding Dependency Case Management and medical case

management). The transition must ensure Care Coordination may not exceed 90 days during which time both a case manager and a care coordinator may provide services to the same individual unless a longer duration is specifically approved by the Department. The transition plan shall be designed to ensure a warm hand-off and successful case management engagement.

NETWORK SERVICE PROVIDER RESPONSIBILITIES

1. Assess organizational culture and develop mechanisms to incorporate the core values and competencies of Care Coordination into daily practice.
2. Utilize a standardized level of care tool and assessments to identify service needs and choice of the individual served.
3. Serve as single point of accountability for the coordination of an individual's care with all involved parties (i.e., criminal or juvenile justice, child welfare, primary care, behavioral health care, housing, etc.).
4. Engage the individual in their current setting, such as the crisis stabilization unit (CSU), SMHTF, homeless shelter, detoxification unit, etc. Individuals served should not be expected to come to the care coordinator.
5. Develop a care plan with the individual based on shared decision-making that emphasizes self-management, recovery and wellness. This must include transition to community-based services and/or supports.
6. Provide frequent contact within the first 30 days of services, which could consist of visits daily to three times per week. This includes telephone contact or face-to-face contact (which may be conducted electronically). Leaving a voicemail is not considered contact. If the individual served is not responding to attempted contacts, the provider must document this in the clinical record and make active attempts to locate and engage the individual.
7. Provide 24/7 on-call availability.
8. Coordinate care across systems, to include behavioral and primary health care as well as other services and supports that impact the social determinants of health.
9. Assess the individual for eligibility of Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Veteran's Administration benefits, housing benefits, and public benefits, and assist them in obtaining eligible benefits. When applying for SSI or SSDI benefits, providers must use the SSI/SSDI Outreach, Access, and Recovery (SOAR) application process. Free training is available at: https://soarworks.prainc.com/course/ssissdi-outreach-access-and-recovery-soar-online-training
10. For individuals who require medications, ensure linkage to psychiatric services within 7 days of discharge from higher levels of care. If no appointments are available, document this in the medical record and notify the managing entity.
11. Coordinate with the managing entity to identify service gaps and request purchase of needed services not available in the existing system of care.
12. Develop partnerships and agreements with community partners (i.e., managed care organizations, criminal and juvenile justice, community based care organizations, housing providers, federally qualified health centers, etc.) to leverage resources and share data.
13. Notify the Managing Entity of individuals identified for Care Coordination from the priority population specified in section II.1.c

CARE COORDINATION ALLOWABLE COVERED SERVICES

Care Coordination is a bundled service approach that is reported through an expenditure Other Cost Accumulator in accordance with Pamphlet 155-2. Pursuant to Ch. 65E-14.014, F.A.C., providers may not bill for services for individuals who have third party insurance coverage when the services provided are paid under the insurance plan or recipients of Medicaid, or another publicly funded health benefits assistance program, when the services provided are paid by said program. The following is a list of allowable covered services as defined in Ch. 65E-14.021, F.A.C.

6. Outreach
7. Assessment
8. Crisis Support/Emergency
9. Recovery Support
10. Supportive Housing
11. Intervention

For additional information, please refer to DCF Guidance 4, Care Coordination:
https://www.myflfamilies.com/service-programs/samh/managing-entities/2022-contract-docs.shtml

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Care Coordination Teams

The provider agencies will provide transition services through their Care Coordination Teams. Critical Time Intervention (CTI) will be one of the evidenced-based practices utilized to effectively transition individuals from higher levels of care. Care Coordination Teams will provide an Intensive Case Management Team approach in conjunction with the BBHC Care Coordinator, which will focus on the individuals' needs, determine level of care, link with existing and newly identified services and supports. The Care Coordination Team will consist of a licensed clinician, an intensive case manager, and a peer specialist. The caseload of each team will range between 15-20 clients. The teams will conduct weekly treatment team meetings and will provide assessment/clinical services, intervention/crisis support, case management, and peer support. The services provided by the Care Coordination Teams are time-limited, with a heavy concentration on educating and empowering the person/family served, engaging and getting to know the person's needs and natural supports, and providing a single point of contact until a person is adequately connected to the ongoing care that meets their needs. The Care Coordination Teams will be available 24/7 for crisis issues.

The Critical Time Intervention Model (CTI) is the evidenced based practice used for the Care Coordination program. The characteristics of this model include:

Principles of CTI:

1. Focuses on a critical transition period and is time-limited.
2. Enhances continuity of care, aims to prevent recurrent homelessness, incarcerations and placement in higher levels of care such as hospitals, receiving facilities, crisis stabilization, inpatient facilities, detox, etc.
3. Identifies and strengthens formal and natural community supports.
4. Complements rather than duplicates existing services.

Phases of CTI and Treatment Planning:

- Pre-CTI: Services begin before an individual is discharged from their placement and to establish an initial relationship before the transition begins.

- Phase 1: Transition to the Community – Frequent contact with the individual in the community, focus on engaging individual with services, identifying and addressing housing-related issues in order to prevent homelessness or housing instability. A transition plan is implemented while providing emotional support.
    - Complete CTI Phase Plan & Treatment Plan Form – At the beginning of phase 1. Treatment plans should be completed within two weeks of authorization.
    - Specify goals, reason and strategies for goals for the corresponding CTI phase.
    - Complete ongoing progress notes documenting interactions with client. Discharge planning discussion should occur throughout the phases.
    - Complete the Summary of Goals form within two weeks prior to the second phase indicating status of goals for Phase 1.
    - Complete LOCUS
    - Participate in Utilization Review

- Phase 2: Tryout – The team encourages individuals to manage problems independently after connecting them to supportive services.
    - Complete CTI Phase Plan & Treatment for Phase 2

- Specify goals, reason and strategies for goals for the corresponding CTI phase
- Complete ongoing progress notes documenting interactions with client. Discharge planning discussion should occur throughout the phases.
- Complete the Summary of Goals form within two weeks prior to the third phase indicating status of goals for Phase 2.
- Complete LOCUS
- Participate in Utilization Review

- Phase 3: Transfer of Care - Promotes transfer from CTI to other formal and informal community supports and termination of CTI services occurs once a support network is safely in place.
  - Complete CTI Phase Plan & Treatment for Phase 3
  - Specify goals, reason and strategies for goals for the corresponding CTI phase
  - Complete ongoing progress notes documenting interactions with client.
  - Complete the Summary of Goals form within two weeks prior to the end of the third phase indicating status of goals for phase 3 and while enrolled in the Care Coordination program.
  - Complete LOCUS
  - Document client outcome and transition from the team including documentation of a warm hand-off meeting at the next level of care.
  - Discharge

Services Provided per Treatment Phase

Phase 1/Months 1-3:

Using CTI, The Care Coordination Team provides assessments of individual needs, develops and implements an individualized treatment plan of service to meet those needs. During this period, the Care Coordination Team frequently engages with the individual making home visits, providing services such as introducing the individual to providers, meeting with caregivers, and helping the individual access and connect with service providers that can potentially be a part of their support system. Focus is on meeting the individuals' immediate needs such as housing, food, medical care, medication management as well as therapeutic services. Individual is accompanied when connecting to with community providers and receives assistance accessing benefits (Medicaid, Disability, etc.).

Phase 2/Months 4-6:

Using CTI, The Care Coordination Team will again assess the individual and continue to support the individuals' engagement and participation in services. The individuals' ability to use problem-solving skills to navigate independently is assessed. As needed, case management, community-based visits and services is provided along with psychoeducation about becoming independent and being able to self-manage and navigate community services. The Care Coordination Team begins to decrease the intense level of services provided during months 1-3. There are less frequent meetings, problem solving, and troubleshooting is provided along with crisis interventions as needed.

Phase 3/Months 7-9:

Using CTI, The Care Coordination Teams assess the individual's level of functioning and readiness for discharge from the Care Coordination Team. The Care Coordination Team continues to remain available to help the individual problem solve and utilize providers and natural support systems. During this period, the individual along with their providers and natural supports will agree on a long-term support system and plan in order to help the individual remain stable in the community. Prior to discharge a final meeting is held to recognize the individual achievements and the ongoing plan that has been agreed upon.

Reports:

A. Care Coordination monthly census is due to the BBHC Care Coordinator by the 5th of the month.

B. The Care Coordination provider waitlist and screening list is due to the BBHC Care Coordination Manager weekly on Fridays by 12 PM.

For additional information, please refer to DCF Guidance 4, Care Coordination:
https://www.myflfamilies.com/sites/default/files/2023-06/Guidance%204%20Care%20Coord%20%202023%2007%2001.pdf
https://www.myflfamilies.com/service-programs/samh/managing-entities/2022-contract-docs.shtml

For additional information, please refer to the BBHC Care Coordination Manual.

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XXXVIII. Peer Navigation Program

Purpose and Goals:
The Peer Navigation Program was implemented in response to the statewide initiative, called 4DX, which includes a goal to reduce recidivism for individuals, admitted to an acute care, crisis stabilization, or detoxification unit by. This program includes embedding a Care Coordination Team (CCT) Peer Navigator daily into each high level of care unit funded by BBHC. The CCT Peer Navigator will be introduced as a part of the treatment team and provide recovery-oriented education and support of peer services available in the community.

Eligibility Criteria:
The CCT Peer Navigator, unit treatment team, and BBHC will work closely as a team with a focus to provide support to individuals who are experiencing their first or second admission to each unit, along with those who are considered high utilizers of care to engage and provide short term support and to bridge the connection to after care upon discharge. The CCT Peer Navigator will be a support to the existing Power of Peers (POP) initiative, which has been providing community-based peer support with a longer duration of services, which began with the high utilizers.

The CCT Peer Navigator will work in collaboration with the inpatient units using a care coordination approach in assessing and assisting individuals to:

Identify their needs and to obtain and maintain self-sufficiency
Complete and maintain the recovery capital scale assessment to engage and collaborate with individuals.
Assist to establish goals that facilitate self-empowerment.
Work in partnership with other programs to meet the needs of the individuals.

Program Process:
The CCT Peer Navigator will be introduced to the individual in person or via video conferencing or telephonically, based on BBHC data and in collaboration with unit staff.

While the person served is being stabilized, the peer navigator may begin engagement daily to introduce navigation services with the consideration of what the individual may identify as their needs and preferences.

Upon engagement/assessment and relationship building, the peer navigator may assist with referrals to a community provider and linkages to programs and/or local resources. Peer navigator engagement would exist during the acute care stay but would not exceed 4 weeks post-discharge from the unit, unless request to extend services have been approved.

If the individual needs longer term support, they can be referred and transferred through a warm handoff to a Power of Peers provider for longer-term peer support.

While on the unit, the CCT Peer Navigator may:
- Meet individually or in small groups to discuss an introduction to wellness plans.
- Assist participants in determining a plan of action to overcome existing barriers and work with participants in their attainment of self-sufficiency and wellness.
- Begin to develop individualized goals.
- Introduce wellness plans with the individual and in collaboration with the unit treatment team to

prepare for their discharge and plan for aftercare in collaboration with a final discharge.

- Telehealth: The use of technology presents another promising practice in coordinating care, specifically as it related to access. Please note that telehealth/telephonic connections have been used during the COVID-19 health crisis and have shown thus far to be helpful in continuing to serve individuals in Care Coordination programs. Please see Guidance Document 4, which references a Department of Veterans Affairs (VA) initiative, which piloted a care coordination telehealth project and appeared promising. Telehealth might be useful for continued use during times of crisis and as needed if the client and or provider are impaired in meeting face to face.

It is important for the CCT Peer Navigator to effectively communicate, listen, and understand the problems, concerns, and barriers faced by individuals and/or families. The CCT Peer Navigator can introduce the program and services through various formats including but not limited to workshops, trainings, events and support groups. Creating a "natural support" can make a difference in how well the person succeeds in the community.

Program supervision and oversight:

CCT Peer Navigators will be required to attend supervision and regular meetings/calls as needed by the Provider and the Unit to which they are assigned. In addition, there will be a licensed clinician providing oversight for the CCT Peer Navigators via a weekly conference call to ensure any issues can be addressed professionally and swiftly, especially if clinical intervention is needed.

Program time allocation:

- CCT Peer Navigators will spend 75 percent of their work week on the acute care unit. Communication may be accomplished via telephonic/telehealth.
- The remaining 25 percent of the worktime is utilized by the CCT Peer Navigator with the follow up necessary for recently discharged individuals.

The time spent off the unit by the CCT Peer Navigator with the individual allows for short-term support in the community and then if needed, connection to a Peer Specialist if needed.

Based on the success of this program, it is anticipated that inclusion of these facilities and linkage to peers in recovery, this will result in a reduction of readmissions for Baker Acts and/ or detoxification.

BBHC Requirements and Training:

The CCT Peer Navigators will participate in the designated trainings specific to the unit they are assigned, which may vary. Training may include local, state, and federal standards and regulations pertaining to the provision of services.

1. Complete WRAP (Wellness Recovery Action Plan) Training within six (6) months of employment.
2. Complete CCT Peer Specialist Training to obtain certification through the Florida Certification Board within eighteen months (18 months) of hire.

Reports and Outcomes:

The Peer Navigator will submit a Monthly Census Report due by the 5th of the month.

XXXIX. Care Coordination Team – Child Welfare (CW)

1. Definition of the Program:

Section 394.4573(1)(a), F.S., defines Care Coordination-CW as "the implementation of deliberate and planned organizational relationships and service procedures that improve the effectiveness and efficiency of the behavioral health system by engaging in purposeful interactions with individual who are not yet effectively connected with services to ensure service linkage."

Care Coordination-CW is the organization of care activities between two or more participants including the family served (with consent), involved in the family's care to facilitate the effective delivery of behavioral health, primary health care, developmental, and mental health services. The population to be served through Care Coordination-CW will be child welfare families that have experienced a judicial removal episode due to caregiver Substance Use Disorder (SUD). With priority given to caregivers with Opiate Use Disorder (OUD). It offers the opportunity to share information in a timely manner and ensures the families being served are followed and supported as they progress through their recovery process. In child welfare, the standard practice has been that once the case is closed, the family may no longer receive the services and support needed to maintain the gains achieved during the life of the case. Due to a lack of support, many of these families cycle through the child welfare system experiencing multiple episodes of removal. In turn, the caregiver's cycle through the mental health/substance abuse system, and the children experience the repeated trauma of removal and the negative impact of their caregivers(s) SUD. This leads to the de-compensation of the family unit and creates immense costs for multiple publicly funded systems.

2. Purpose of the Program:

Care Coordination Teams (CCT)-CW will provide supportive services to families in the child welfare system, or who are at risk entry into the child welfare system, due to caregiver SUD (Substance Use Disorder), with priority given to OUD (Opiate Use Disorder). Care Coordination Teams provide an Intensive Case Management Team approach, in conjunction with the support of a BBHC Care Coordination Manager, the Child Advocate (CA) assigned to the case, ChildNet Care Coordination Manager, the family and all providers serving the family. The CCT-CW will assist the CA and the family by staging referrals, ensuring families are linked in a timely manner to the appropriate services, and monitoring the families progress in services. CCT-CW will also facilitate families in building an informal Recovery Support network.

Critical Time Intervention (CTI) will be one of the evidenced-based practices utilized to effectively transition families from the child welfare system. which will focus on the family's strengths and needs to determine the appropriate level of support needed, and link with existing and newly identified services and supports. Each Care Coordination-CW Team will consist of an intensive case manager, and a peer specialist, supervised by a licensed clinician. The caseload of each team will range between 10-15 families. The teams will conduct weekly treatment team meetings and will coordinate for assessment/clinical services, and will directly provide intervention/crisis support, case management, and peer support. The services provided by the Care Coordination-CW Teams are time-limited, with a heavy concentration on educating and empowering the family served, engaging and getting to know the family's strengths, needs and natural supports, and providing a single point of contact until a family is adequately connected to the ongoing support needed to maintain long-term recovery. The Care Coordination-CW Teams will be available 24/7 for crisis support.

3. Goals of the Program:

Care Coordination-CW Short-Term Goals:

- Prioritize the family's wellness and enhance their natural recovery supports within the community.
- Assist the family with meeting case plan goals by staging appropriate referrals.
- Communicate with the Child Advocate and support the family with communicating on progress.
- Increase overall family stability and wellbeing, thereby decreasing the risk factors associated with another removal episode.
- Improve transitions from acute and restrictive services mandated by child welfare to; community-based services, family supports, and the maintenance of long-term family and individual recovery.

Care Coordination-CW Long-Term Goals:

- Help service providers shift from an acute care model to a Recovery-Oriented System of Care (ROSC) Model.

Help communities provide a wide array of services and supports tailored to meet the diverse needs specific to each family and each member within the family unit.

4. Admission Criteria for the Program:

- Families must have experienced a judicial intervention due to caregiver SUD, with priority given to caregivers with OUD.
- Child Welfare families who are not effectively connected with services and supports.
- Child Welfare families who are transitioning successfully from mandated child welfare services to effective community-based care.
- Child Welfare families who are high utilizers of services in behavioral health, primary care, peer, natural supports, housing, education, and vocational.
- Child Welfare family's needs can include at-risk to manageable substance abuse problems with a high recidivism rate into SUD treatment and further episodes of removal due to caregiver SUD/OUD.
- Non Child Welfare families that have been identified as high risk of entering into the Child Welfare System due to parental/caregiver substance use disorder.

5. Treatment Model for the Program:

The primary Treatment Model utilized by the Care Coordination-CW Teams is the evidence-based practice (EBP), Critical Time Intervention (CTI). Critical Time Intervention is used to provide recovery-oriented services to individuals and families receiving Care Coordination-CW. This model is on the SAMHSA National Registry of Evidence-Based Programs and Practices (NREPP) and was "designed as a short-term intervention for people adjusting to a "critical time" of transition in their lives". Within the CTI model, Motivational Interviewing, Wellness Recovery Action Planning (WRAP) and Family Wellness Recovery Action Planning (F-WRAP) are also utilized to ensure that families receive treatment/ancillary services to meet their needs. The Teams receive training and coaching to ensure program fidelity. More information about CTI can be found on www.criticaltime.org.

VI). Covered Services for the Program:

1. Outreach
2. Assessment
3. Crisis Support/Emergency
4. Recovery Support
5. Supportive Housing
6. Intervention

VII) Phases of the Program:

- Pre-CTI: Services begin before Termination of Child Welfare Supervision (TOS) to establish an initial relationship before the transition begins.
- Phase 1: Transition to the Community – Frequent contact with the family in the community, focus on engaging the family with services, identifying and addressing housing-related issues in order to prevent homelessness or housing instability, and identifying and addressing what is needed to support long-term family recovery. A transition plan is implemented while providing emotional support.
    - Complete CTI Phase Plan & Treatment Plan Form – At the beginning of phase 1. Treatment plans should be completed within two weeks of authorization
    - Completion of the Recovery Capital Scale Inventory (RCSI). This inventory is to be reviewed with the caregivers at the commencement of each ongoing phase.
    - Specify goals, reason and strategies for goals for the corresponding CTI phase
    - Complete ongoing progress notes documenting interactions with the family. Discharge planning discussion should occur throughout the phases.
    - Complete the Summary of Goals form within two weeks prior to the second phase indicating status of goals for Phase 1
    - Participate in Utilization Review led by BBHC Care Coordination Manager and CCT-CW Care Coordinator
    - If the team is unable to complete the WRAP in Phase I due to family crisis, this is to be documented throughout the client record and is to be completed when appropriate as determined by the provider, family and funding source.

- Phase 2: Tryout – The team encourages families to manage problems independently, with the assistance of natural supports, after connecting them to supportive services.
    - Complete CTI Phase Plan & Treatment for Phase 2
    - Specify goals, reason and strategies for goals for the corresponding CTI phase
    - Complete ongoing progress notes documenting interactions with the family. Discharge planning discussion should occur throughout the phases.
    - Complete the Summary of Goals form within two weeks prior to the third phase indicating status of goals for Phase 2

- Phase 3: Transfer of Care - Promotes transfer from CTI to other formal and informal community supports and termination of CTI services occurs once a family support network is safely in place.
    - Complete CTI Phase Plan & Treatment for Phase 3
    - Specify goals, reason and strategies for goals for the corresponding CTI phase
    - Complete ongoing progress notes documenting interactions with the family
    - Complete the Summary of Family Centered Goals form within two weeks prior to the end of the third phase indicating status of goals for phase 3 and while enrolled in the Care Coordination-CW program

- Document caregiver and family outcomes and transition from the team including documentation of a warm hand-off meeting at the next level of care
- Discharge

Monthly Progress Reports shall be completed by the 10th of each month and uploaded to the FSFN file cabinet. Monthly Progress Reports format is provided through the BBHC Cognito link. This form is to be used and not to be substituted.

It is to be noted that a Wellness Recovery Action Plan cannot be completed when a family is in crisis.

VIII) Staffing Requirements of the Program:

CCT-CW Supervisor (1.0 FTE)

Must be a full-time employee and possess a Florida license in one of the following professions:

(a) Mental Health Counselor;
(b) Clinical Social Worker;
(c) Marriage & Family Therapist;

The Supervisor is responsible for administrative and clinical supervision of the CCT-CW and functions as a practicing clinician. The CCT- CW Supervisor must have at least five (5) years of full-time work experience with children and families in the child welfare system, as well as prior supervisory experience. This position will ensure that the program complies with Chapter 394, F.S. and Chapters 65E-5, 65E-12, and 65E-14, F.A.C.

Case Manager (1.0 FTE)

The Case Manager must have a minimum of a bachelor's degree in a behavioral science. Case Managers must have a minimum of one (1) year of work experience with children and families within the child welfare system. Case Managers are to be supervised by the CCT-CW Supervisor. Case Managers are primarily responsible for providing or coordinating the required services on behalf of the families as more fully set forth below.

Certified Peer Specialists (1.0 FTEs)

This individual will use their own unique, life altering personal recovery experience to guide and support others who are in recovery or are in the process of beginning their recovery journey. This individual must personally be in recovery from substance use disorder (SUD). Additionally, they must be trained in, and use the Family Wellness Recovery Action Planning (F-WRAP) recovery model as part of their treatment protocol, as well as individual WRAP for the caregiver(s). The Peer Specialist must obtain a Certified Recovery Peer Specialist (CRPS-A) certification with the Florida Certification Board.

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XL. Care Coordination Team – Children

PURPOSE AND GOALS

Care Coordination serves to assist children and their families in the process of transitioning from Children Crisis Stabilization Units (CCSU), Statewide Inpatient Psychiatric Program (SIPP) and after an episode of Mobile Response Team (MRT) intervention until they are effectively connected with services and supports needed to transition to appropriate level of care. The Children Care Coordination Team (CCCT) will ensure that the children are effectively connected with the services and supports they need to transition successfully from higher levels of care to effective community-based care. It will also assist the families of these children to support and guide them through the process. This includes services and supports that affect both the children and families' well-being, such as primary physical health care, housing, and social connectedness. Care Coordination connects systems including behavioral health, primary care, peer and natural supports, housing, education, vocation, and the justice systems. It is time-limited, with a heavy concentration on educating and empowering the person served and provides a single point of contact until a person is adequately connected to the care that meets their needs.

The short-term goals of implementing Care Coordination are to:

- Improve transitions from acute and restrictive to less restrictive community-based levels of care.
- Decrease avoidable hospitalizations, inpatient care, incarcerations, and homelessness; and
- Focus on the child and family's wellness and community integration.

The long-term goals of implementing Care Coordination are to:

- Shift from an acute care model of care to a recovery model; and
- Offer an array of services and supports to meet an individual's chosen pathway to recovery.

PRIORITY POPULATIONS

Individuals at a CSU and SIPPs that require but are not limited to services such as behavioral health, primary care, peer and natural supports, housing, education, and employment.

- With history or previous CSU/Baker Acts.
- Who have high utilization of services.
- With multiple service needs with at least one of the problem areas identified as "severe", pregnant youth, IV drug users, and/or serious mental illness.
- With a Serious Mental Illness (SMI) awaiting placement in a civil state mental health treatment facility (SMHTF) or awaiting discharge from a SMHTF back to the community.
- With a SMI and/or substance use disorder (SUD) who account for a disproportionate amount of behavioral health expenditures.
- With a SMI and/or SUD who have a history of multiple arrests, involuntary placements, or violations of parole leading to institutionalization or incarceration.
- With involvement in the child welfare system or behavioral health system who are suspected to be involved or are involved in human trafficking.
- Without a strong support system that can support the child with ongoing services in the community.

NETWORK SERVICE PROVIDER RESPONSIBILITIES

Network Service Provider responsibilities include:

1. Engage the individual in their current settings, CCU and SIPPs.
2. Utilize a standardized level of care tool and assessments to identify service needs and choice of the individual served.
3. Serve as single point of accountability for the coordination of a child's care with all involved parties (i.e., juvenile justice, child welfare, primary care, behavioral health care, housing, etc.).
4. Develop a plan with the children and family based on shared decision making that emphasizes self-management, recovery, and wellness. This must include transition to community-based services and/or supports.
5. Provide frequent contact during the time of services,
6. Coordinate care across systems, to include behavioral and primary health care as well as other services and supports that impact the social determinants of health.
7. For children who require medications, ensure linkage to psychiatric services
8. Coordinate with the managing entity to identify service gaps and request purchase of needed services not available in the existing system of care.
9. Develop partnerships and agreements with community partners (i.e., managed care organizations, criminal and juvenile justice, community-based care organizations, housing providers, federally qualified health centers, etc.) to leverage resources and share data.
10. Ensure linkage with Managed Care case manager when applicable

CARE COORDINATION ALLOWABLE COVERED SERVICES

The following is a list of allowable covered services as defined in Ch. 65E-14.021, F.A.C.

- Outreach
- Crisis Support/Emergency

XLI. Transitional Voucher Procedure

Purpose:

This project provides care coordination and vouchers to purchase treatment and support services for adults transitioning from Florida Assertive Community Treatment (FACT) teams, acute crisis services, and institutional settings to independent community living; and individuals experiencing homelessness, at risk for homelessness, or receiving care coordination services. Vouchers may also be utilized to assist eligible individuals maintain their current level of care by achieving residential stability. The Transitional Voucher project is a flexible, consumer-directed voucher system designed to bridge the gap for persons with behavioral health disorders as they transition from acute or more restrictive levels of care to lower levels of care. The intent of this project is to enable individuals to live independently in the community with treatment and support services based on need and choice and build a support system to sustain their independence, recovery, and overall well-being.

The project aims to:

- Prevent recurrent hospitalization and incarceration;
- Provide safe, affordable, and stable housing opportunities;
- Maximize use of FACT resources and community supports;
- Increase participant choice and self-determination in their treatment and support service selection; and
- Improve community involvement and overall quality of life for program participants

The service is time limited financial assistance based on the individuals' needs and care plan objectives. Individuals have limited resources available or they have exhausted other financial resources including insurance; and have complex needs, which may require multi-agency involvement.

All transitional voucher requests must receive formal agency approval/denial utilizing the authorized form and approval by the designated BBHC Care Coordinator.

Eligibility (All funds are time-limited):

Persons eligible for services under this component must be currently receiving Department-funded SAMH services pursuant to Chapters 394 and 397, F.S., and must meet one the following alternative characteristics:

A. Experiencing homelessness; meaning an individual who lacks housing, including:

1. An individual whose primary overnight residence is a temporary accommodation provided by a supervised public or private facility, or

2. An individual who resides in transitional housing, or

3. An individual at risk for homelessness

Or

B. Receiving Care Coordination services pursuant to **Guidance 4.**

Or

C. Participating in FACT teams not listed in Table 1 and ready to transition to a lower level of care.

Individuals must be receiving substance use and/or mental health services and be served by a Care Coordination Team funded by BBHC.

Allowable Expenses

1. Transitional Voucher services may be authorized only to the extent that they are reasonable, allowable and necessary as determined through the assessment process; are clearly identified in the care plan; and only when no other funds are available to meet the expense.

2. The person served is the primary decision maker as to the services and supports to be purchased and from what vendor those services are procured.

3. Allowable expenses include the following Covered Services as defined by Rule 65E-14.021, F.A.C.:

a. Aftercare;
b. Assessment;
c. Case Management;
d. Day Care;
e. Day Treatment;
f. Incidental Expenses;
g. In-Home and On-Site;
i. Intervention;
j. Medical Services;
k. Medication-Assisted Treatment;
l. Outpatient;
m. Recovery Support;
n. Respite Services;
o. Substance Abuse Outpatient Detoxification;
p. Supported Employment; and
q. Supportive Housing/Living.

4. Allowable Incidental Expenses include time limited transportation, childcare, housing assistance, clothing, educational services, vocational services, medical care, housing subsidies, pharmaceuticals and other incidentals as approved by the Managing Entity in compliance with Rule 65E-14.021, F.A.C.

5. Network Service Providers and non-Network Service Providers must adhere to:

a. State purchasing guidelines for allowable expenses as promulgated by the Department and the Department of Financial Services
b. The requirements of Rule 65E-14, F.A.C., and
c. Managing Entity protocols regarding allowable purchases.

6. Managing Entities must request prior approval by the Department for the use of Transitional Voucher funds to purchase services from a licensed Assisted Living Facility (ALF). When utilizing an ALF, the request must include documentation showing due diligence was exercised in searching for less restrictive housing in these cases.

Restrictions and Limitations:

- Voucher funds are the payer of last resort
- Directly support documented treatment/service goals of the client
- Receipts must be maintained by the agency
- Invoice and treatment plan for requested service must be uploaded to the Transitional Voucher request form in the Cognito link.
- Individuals should increasingly demonstrate the ability to self-manage and/or transition to other fund sources based on access to disability benefits, insurance, employment, and/or housing vouchers
- Requests for Assisted Living Facilities (ALFs) rental assistance require DCF for approval.

Housing funds must be for allowable placements such as licensed facilities or certified recovery homes or provide a current lease agreement. Eligible Housing Subsidy requests will include those allowable under the DCF guidelines such as licensed facilities, FARR certified homes, and/or a current lease agreement.

Provider Responsibilities:

Providers shall:

1. Provide Care Coordination services to coordinate services with other providers and organizations to ensure the needs of the participant are addressed at any given time;

2. Utilize the SSI/SSDI Outreach, Access, and Recovery (SOAR) model to assist project participants in applying for SSI/SSDI benefits;

3. Monitor each participant's progress and work with providers to adjust services or providers as needed;

4. Ensure Transitional Voucher funds are used only for services and supports that cannot be paid for by another funding source; specifically:

a. Network Service Providers and participants are responsible for locating other non-SAMH payor sources for services or supports prior to using Transitional Voucher funds.

b. In collaboration with the participant, Network Service Providers must certify no other payer source is available and due diligence was exercised in searching for alternative funding prior to the use of Transitional Voucher funds. Network Service Providers must submit a signed certification for each use of Transitional Voucher funds with the monthly invoice.

5. Establish accurate record keeping that reflects specific services offered to and provided

for each participant; and

Agency Responsibilities:
It is the responsibility of the agency to develop an agency-specific policy and procedure to ensure accuracy, accountability, and responsibility for the funds requested and approved.

- The information will include initials or record identifier of individuals served
- Amount expended, service/item purchased, date of purchase, case manager involved

Procedure for Accessing Transitional Voucher Funds:

- Case Manager/Agency Designee will complete the electronic Transitional Voucher Request/Application on behalf of the individual being served, using the Cognito link below:

  https://www.cognitoforms.com/BrowardBehavioralHealthCoalition/carecoordinationtemporarytransitionalvoucherrequestapprovalform2

- The Transitional Voucher Request/Application will be reviewed internally by the Agency Supervisor or Designee.
- After being reviewed by the Supervisor or Agency Designee the following must be submitted to the corresponding BBHC Care Coordinator overseeing the client's Care Coordination Team:
  - Transitional Voucher Request/Application
  - Copy of the current treatment plan justifying the need for the requested service
  - Copy of Invoice for requested service
  - The Transitional Voucher Assessment Tool will be submitted for Assisted Living Facility Requests
- BBHC Care Coordinator will review and provided an electronic disposition return the request the Case Manager/Agency Designee.
- For approved requests, the Case Manager/Agency Designee is responsible for following their agency's internal policy in order to obtain and disburse the requested funds
- Case Manager/Agency Designee is responsible for following their agency's internal policy in order to obtain and disburse the requested funds
- The Agency Designee is responsible for documenting and maintaining records of the Transitional Voucher funds provided on behalf of their clients
- BBHC Care Coordinators will also maintain a monthly tracking log of Transitional Voucher funds that have been approved.

DCF Guidance 29-Transitional Voucher Program can be referenced for further information:
https://www.myflfamilies.com/service-programs/samh/managing-entities/2022-contract-docs.shtml

Attachment(s):
Transitional Voucher Request/ Approval Form
Treatment Plan
Assessment Tool
Transitional Voucher Program Assessment Scale

CCT Cognito Link for Transitional Vouchers:

https://www.cognitoforms.com/BrowardBehavioralHealthCoalition/carecoordinationtemporarytransitionalvoucherrequestapprovalform2

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Care Coordination- Temporary Transitional Voucher Request/ Approval Form

Must be submitted for proposed transitional expense, along with the treatment plan and invoice. All costs shall be consistent with the requirements of the contract, the State of Florida Reference Guide for State Expenditures, and applicable Florida statutes, rules, and regulations.
Case Manager/Requestor required, First and Last are required.
First and Last are required.
Request Date: required,
6/12/2020
Case Manager/requestor Email required, Case Manager/requestor Email is required.

Case Manager/requestor Email is required.
Client's Name required, First and Last are required.

First and Last are required.
Date of Birth: required, Date of Birth is required.

Date of Birth is required.
Provider Name required,

- (•) Archways, Inc.

Banyan Health Care System
Age required; Age is required.

Age is required.
Gender required; Gender is required.

- ☐ Male
- ☐ Female
- ☐

Gender is required.
SSN: required, SSN: is required.

Transitional Voucher Program Assessment Scale

Domains and Definitions - Highlight or Circle Assessed Domains

	1	2	3	4	5
High Risk Behaviors (see page 3)	None of the 11 high risk behaviors in at least the past year	None of the 8 highest risk behaviors in at least the past year	None of the 11 high risk behaviors in at least the past 6 months	None of the 8 highest risk behaviors in at least the past 6 months	One or more of the 8 highest risk behaviors on the last 6 months.
Activities of Daily Living	Able to perform self-care tasks (bathing, toileting, cooking, food shopping). Able to use bus independently.	Able to cook food shop for self. May require occasional prompts or assistance with other self-care tasks. Consistent access to reliable transportation (i.e. bus, family, friends).	Able to cook food shop for self. May require occasional prompts or assistance with other self-care tasks. No consistent access to reliable transportation (i.e. bus, family, friends).	Requires frequent prompting, monitoring or step-by-step cueing to perform one or more self-care tasks No consistent access to reliable transportation.	Demonstrates consistent failure to maintain personal hygiene appearance, and self-care near usual standards. No access to reliable transportation. .
Community Integration	Consumer works/volunteers 20 hrs/week or more AND exhibits at least one of the following: 1) Consistent attendance at community groups/clubs/ religious services; 2) Consistent visits with friends/relatives	Consumer works/volunteers 10 – 19 hrs/week AND engages in at least one of the following: 1) Consistent attendance at community groups/clubs/ religious services; 2) Consistent visits with friends/relatives;	Consumer does not work/volunteers (or does so less than 10 hrs/wk) but attends community groups/clubs/ religious services AND/OR visits friends/relatives on a regular basis.	Consumer does not work/volunteers (or does so less than 10 hrs/wk) and sometimes attends groups/clubs/ religious AND/OR sometimes visits with friends/relatives	Consumer does not work, rarely leaves home and has few or no friends

Consumer Name:_____

Consumer Signature: _____ **Date:** _____

Provider Staff Name: _____

1

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Provider Staff Signature: _____ Date: _____

	1	2	3	4	5
Stable Housing (see page 3)	Stably housed in the community for more than 12 months	Stably housed in the community for 7 - 12 months	Stably housed in the community for 1 - 6 months	In community living for less than 1 month or in another setting, but not homeless	Homeless living situation or had days homeless in last 6 months
Treatment Participation	Excellent (independently and appropriately accesses services)	Good (able to partner and can use resources independently)	Fair (No independent use of services or only in extreme need)	Poor (relates poorly to providers, avoids independent contact with providers)	No Participation (no contact with providers, does not participate in services at all)
Psychiatric Medication Use	Either no medications prescribed or adheres most of the time	For last six months takes meds most of the time but may need some verbal assistance,	Takes meds sometimes and/or may need physical assistance	Takes meds rarely or never as prescribed OR requires substantial help to take meds	Takes meds rarely or never as prescribed OR refuses meds OR level of assistance is unknown
Psychiatric Hospitalization /Crisis management/ Detoxification	No inpatient admissions, detox or ER visits in previous 12 months. 0-3 Months 4-6 Months 7-9 Months 10-12 Months	No inpatient admissions AND less than 3 ER/ Detox visits in previous 12 months.	Up to 1 inpatient admission and no ER/Detox visit OR 4 – 9 ER visits and no inpatient admissions in previous 12 months	No category 4 for this domain	2 or more inpatient admissions OR 10 or more ER/ Detox visits in previous 12 months
Forensic	Had no arrests and spent no days incarcerated in past 12 months 0-3 Months 4-6 Months 7-9 Months 10-12 Months Not Forensic	Had no arrests and spent no days incarcerated in past 9 months	Had no arrests and spent no days incarcerated in past 6 months	No category 4 for this domain	Arrested or spent days incarcerated in last 6 months

2

Revised 2.12.19

Substance Use Stages of Treatment (see page 4) Please circle the appropriate number in each box	Consumer assessed at 0 (Client does not abuse drugs or alcohol); OR 8 (In Remission or Recovery) 0-3 Months 4-6 Months 7-9 Months 10-12 Months	Consumer assessed at Stage 7 (Relapse Prevention) OR late phase of Stage 6 (Late Active Treatment)	Consumer assessed in early phase of Stage 6 (Late Active Treatment) OR Stage 5 (Early Active Treatment)	Consumer assessed at Stage 4 (Late Persuasion) OR Stage 3 (Early Persuasion)	Consumer assessed at Stage 2 (Engagement) OR Stage 1 (Pre-engagement)

Date of Assessment Scale: _____ **Score:**_____

Consumer Initials: _____ **Provider Staff Initials:** _____

3

Revised 2.12.19

XLII. Broward Youth Reentry Program (BYRP)

The Broward Youth Reentry Program (BYRP) initially began in 2019 as a collaboration between key community stakeholders providing expertise and insights about the needs of youth with behavioral health issues involved in the criminal justice system who are being sent away to a commitment program. An expansion grant was obtained to continue the program as BYRP2 which focuses on diverting young people ages 12-21 years old with a history of serious and violent chronic offenses with a prolific arrest history leading to repeated detainment or commitment or who are prolific offenders and have repeated episodes of arrest and are detained in commitment for up to 21 days. These arrests and detainments often impede their access to mental health and substance use services. BYRP2 will provide individualized services to meet the mental health and substance use needs of the young people and their families. The goal is to provide the needed supports and services to successfully transition to adulthood in the community and decrease the chances of the youth reoffending. Community-based supervision and aftercare services help to reduce recidivism as well as increase the likelihood of young people attending school and going to work.

Procedure and Program Requirements:

- Referrals for BYRP2 will be accepted from the community, JPOs, community mental health agencies, etc.
- Referrals may l include the following: Current DJJ Face Sheet, Comprehensive Evaluation, Gain Q, signed authorization of release forms, and any other clinical information such as psychological and psychiatric evaluations. BBHC will coordinate with JPO's to obtain required documentation.
- Referrals will be reviewed by the BBHC Clinical Care Integration Coordinator.
- Referrals that meet eligibility will be forwarded to our Program Partners.
- Program Supervisors will review and assign as appropriate.
- Within 48 hours of notification, the provider will attempt to contact the referred young person and their family to obtain consent to participate in the program.
- The provider will schedule a face-to-face or telephonic meeting with the referred individual.
- TIP Coach's will engage the target population and initiate services with the target population and their families.
- All youth in BYRP2 are assigned a Wraparound Facilitator (ages 12-13) or TIP Coach (ages 14-21) and a Youth Peer Specialist (ages 12-21).
    - Wraparound Facilitators work with youth and families to develop a Wraparound plan to achieve the goals identified by the family.
    - TIP Coaches work with youth to develop their Futures Plan to help them identify their goals and needs.
    - Youth Peer Specialist have lived experience and provide youth support and encouragement to achieve and maintain their wellness goals.
    - Youth and Family Peers will formally develop a WRAP Plan for the youth and their families.
    - TIP Coaches, Wraparound Facilitators, and Youth Peer Specialist will continue providing established services to youth and families as well as provide linkage to chosen providers.
- BYRP2 will offer as needed Multi-Systemic Family Therapy (MSFT), Brief Strategic Family Therapy (BSFT), Moral Reconation Therapy (MRT), Thinking for Change, Transition to Independence Process (TIP), Beat the Odds Integrated Group Counseling and Group

Drumming, Individual Placement and Support (IPS), Wellness Recovery Action Plan (WRAP), Trauma Incident Reduction (TIR), Family CPR, Wraparound, Medication Assisted Treatment (MAT), Youth Move, supported employment, supported housing, and supported education. The Housing First model will be used to connect independent youth and/or families to housing. Incidental Funds will be used by participating providers to support youth treatment and recovery plans, and independent living and housing for transition age youth.

- BYRP2 will provide Transition to Independence Process (TIP), Wraparound and Peer Support to all youth.
- Peers and Case Managers will submit monthly progress reports to BYRP the second Friday of each month.
- Peers will participate in Treatment Team Meetings via conference call at least once weekly regarding youth who are in services.
- BYRP Providers and Community Partners will participate in monthly Project Team Meetings.

BYRP Providers will submit monthly invoices by the 5th of each month to the Managing Entity.

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XLIII. Recovery Community Organization (RCO)

Purpose and Goals:

Recovery Community Organizations (RCOs) provide support to the recovery community and their loved ones. RCO's provide a place for members to engage in activities such as advocacy, support groups, wellness, and also provide recovery-focused community education, outreach programs, and peer recovery support services.

Eligibility Criteria:

Individuals and family members of those living with Substance Use and/or Co-Occurring Mental illness seeking supports in recovery.

Covered Services:

1.Outreach
2. Recovery Support (Individual)
3. Recovery Support (Group)
4. Incidentals

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XLIV. Residential Support Coordination

Program Summary

Residential Support Coordination is a service provided through the Taskforce Fore Ending Homelessness for individuals that are at risk of homelessness or are unstably housed or for those that are transitioning out of Residential Treatment Facilities, transitional or respite housing placements, jail release and diversions, acute care facilities, as well as those filtering through the Centralized Receiving Center (CRC) that are not homeless and are within the Broward Behavioral Health Coalition's Provider Network. Broward Behavioral Health Coalition, Inc. (BBHC) will fund 2 Residential Support Coordination positions designated to assist individuals and/or families who have Mental Health or Substance Use disorders with obtaining and maintaining stable and secure housing.

Residential Support Coordinators (RSC) assist individuals with disabilities and their families to develop plans to find the most appropriate services and assistance based on the individual and/or families housing needs. The (RSC) will work closely with Case Managers, Housing Navigators and Peer Support Specialists within BBHC's Provider Network to lend support for linking with long-term housing stability solutions.

- The Residential Support Coordinator (RSC) is the first and best option to help a family determine what services are available to best suit an individual's or family's needs.
- BBHC works closely with Residential Support Coordinators (RSC) in providing referrals for individuals and/or families in need of housing stability assistance.

Scope of Services

Taskforce Force Ending Homelessness, Inc's (RSC) will provide short-term linkage and supports to individuals and/or families that are unstably housed, those that have received eviction notices, those that are set for discharge from Residential Treatment Facilities, Transitional Housing, Respite placements, jail release and diversions, as well as those being discharge from acute care facilities or filtering through the Centralized Receiving Center that are not homeless.

- Individuals and/or families will receive assistance in linkages to community resources that are available to both prevent homelessness and link them with supports to prevent future housing needs by providing information and referrals for diversion and prevention.
- Taskforce Fore Ending Homelessness' (RSC) will participate in BBHC and Community trainings that will enhance their ability to identify and provide appropriate referral linkages for individuals and/or families.

Procedure

- The program can receive referrals from BBHC's Housing and SOAR Entitlements Coordinator, Acute Care Facilities within the BBHC Provider Network, Residential Treatment Facilities, Transitional/Respite Housing Placement providers within the BBHC Provider Network, County Jail Releases, and diversions and through the Centralized Receiving Center that are not homeless.

- RSC will begin engagement daily to introduce RSC services with consideration of what the individual and/or family may identify as their needs. Upon engagement and assessment, the (RSC) may assist with referrals to community providers and linkages to programs and/or local resources. RSC engagement would exist for the first 4 weeks of engagement and is able to be extended if necessary. Longer-term support can be coordinated by the RSC with Network Providers.

XLV. Cultural and Linguistic Competency Plans

Broward Behavioral Health Coalition, as part of its system of care initiative, requires all its network providers to comply with the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards). The CLAS Standards are a set of recommendations, guidelines and mandates established by the U.S. Department of Health and Human Services (HHS) to advance health equity, improve quality and help eliminate health care disparities. The enhanced National CLAS Standards align with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities (HHS, 2010) and the National Stakeholder Strategy for Achieving Health Equity (National Partnership for Action to End Health Disparities, 2011), which aim to promote health equity by providing clear plans and strategies to guide collaborative efforts that address racial and ethnic health dipartites across the country.

A Cultural Linguistic Competence (CLC) Plan assessment tool below was created with the SAMHSA TA Network using the CLAS Standards as benchmarks. This tool is designed for the use to assess the cultural and linguistic competence of service providers. Furthermore, it is a tool for quality assurance and to measure operationalization and implementation.

The tool includes the 4 themes that the CLAS Standards focus on: 1) Introduction: Principal Standard; 2) Governance, Leadership, and Workforce; 3) Communication and Language Assistance; and 4) Engagement, Continuous Improvement, and Accountability. The CLC Assessment Tool also evaluates an organization's progress in two additional domains that are important to cultural and linguistic competence: Family Acknowledgment and Spiritual Cultural Beliefs in Treatment and Discharge.

The CLC Plan is designed to ensure that all of the services and strategies for Broward's System of Care and OCP3 are designed and implemented within the cultural and linguistic context of the children, youth, emerging adults, and families to be served. The overarching goal of the CLCP is to ensure that the system of care adopts a systemic, systematic and strategic approach to increasing the cultural responsiveness of services and supports delivered to children, youth and families. In addition, the CLCP aims to establish a sensitivity for and appreciation of diversity and cultural issues throughout the system of care.

BBHC requires all network providers to maintain a CLC Action Plan based on the Assessment tool. Updates to CLC plans must be submitted annually when requested by CQI Department.

CLC Assessment Tool

Theme 1: Introduction: Principal Standard (Goal of the CLC Plan)

	Statements	Yes/No	Date of Implementation	Data Source	Responsible Party
CLAS Standard 1: Provide effective, equitable, understandable, and respectful quality care and	The plan states that the organization offers effective quality care responsive to diverse cultural and health beliefs and practices.				
	The plan states that the organization offers understandable quality care responsive to diverse cultural and				

services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.	health beliefs and practices.				
	The plan states that the organization offers respectful quality care responsive to diverse cultural and health beliefs and practices.				
	The plan states how the organization collects and recognizes cultural health beliefs.				
	The plan states that the care provided will be provided in the client's preferred language, recognizing their health literacy and other communication needs.				
	The plan acknowledges health literacy and other communication needs and defines what those are or may be for the organization.				

Theme 2: Governance, Leadership, and Workforce

	Statements	Yes/No	Date of Implementation	Data Source	Responsible Party
CLAS Standard 2: Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.	The plan states that the organization annually allocates resources to meeting the diverse cultural and linguistic needs of its clients.				
	The plan revisits its policies and management strategies on an annual basis to determine needs that may need addressing or added.				
	The plan states how often that the CEO and Board meets to set goals to improve diversity and offer continual cultural competence care and training as a part of the strategic plan.				
	The plan details how and when staff members can provide feedback on interactions with LEP and minority populations, to improve interactions and services.				
CLAS Standard 3: Recruit, promote, and support a culturally and linguistically	The plan has protocols in place for recruiting diverse staff members including leadership and governance positions.				
	The plan specifies how organizations place priority on hiring members of staff with added bilingual or multilingual				

diverse governance, leadership, and workforce that are responsive to the population in the service area.	qualifications.				
	The plan specifies how the organization will recruit staff members that represent the service population, which includes advertising job opportunities in foreign languages in various outlets (social media networks, publications, professional organizations' email list serves, job boards, local schools, faith based organizations, training programs, minority health fairs, etc.).				
	The plan states that the organization recognizes staff who continue to meet the diverse needs of clients by offering the individuals internal promotions and other opportunities for upward mobility before seeking external candidates.				
	The plan states that the organization recognizes the diverse cultural beliefs of its employees.				
CLAS Standard 4: Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.	The plan discusses how staff (workforce, leadership and governance positions) are trained on cultural norms, and how they vary by family (such as youth alcohol consumption or physical punishment).				
	The plan states that the organization supports the staff development of its employees, and how it places value on continued education and training in diversity and leadership.				
	The plan states how often staff and leaders receive training.				
	The plan states that the staff is trained on recognizing and responding to cultural health beliefs.				
	The plan states how both internal and external resources are used to educate the governance, leadership, and workforce on cultural beliefs that they may encounter.				
	The plan states that cultural competence in incorporated into staff evaluations and performance reviews.				
	The plan states what is included in the staff training, and how the training is evaluated.				

Theme 3: Communication and Language Assistance

	Statements	Yes/No	Date of Implementation	Data Source	Responsible Party
CLAS Standard 5: Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.	The plan states that the organization offers language assistance to LEP individuals and/or other communication needs at no cost to the client.				
	The plan details the way that clients are made aware of no cost language assistance.				
	The plan states that the organization offers language assistance to LEP individuals and/or other communication needs for access to services in a timely manner.				
	The plan states how program directors, "point of contact staff" or agency's appointed "gatekeeper" are made aware of and trained in language assistance services, policies, and procedures.				
	The plan identifies how language needs are noted in records for individuals seeking care (which may include language needs, "I speak" cards, etc.).				
	The plan states the maximum time that it will take to provide an interpreter and the maximum amount of time for service delivery using a certified interpreter.				
CLAS Standard 6: Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.	The plan states that the organization has the availability of language assistance services clearly displayed.				
	The plan states what language assistance services are available at all times.				
	The plan states how the organization translates appropriate material.				
	The plan states that there is a protocol for verbally informing clients of the availability of services in their preferred language.				
CLAS Standard 7: Ensure	The plan states the protocol for ensuring language assistance providers are certified.				

competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors should be avoided.	The plan states how the organization ensures interpreter competence, including the interpreter's active listening skills, message conversion skills, and clear and understandable speech delivery.				
	The plan states if community brokers are used within the organization.				
	The plan states that untrained individuals and minors should NOT be used as interpreters.				
CLAS Standard 8: Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.	The plan states that the organization has clear, easy to understand multimedia materials and signage in the languages used within the service community.				
	The plan states what multimedia materials are available in various languages.				
	The plan states that there is a formalized process and what the process is for translating materials into languages when the materials are not readily available.				
	The plan notes that the materials have been tested with members of the target audience (such as through focus groups, where members may identify content that may be embarrassing or offensive, suggest cultural practices that may be more appropriate examples, and assess whether the graphics are appropriate and reflect the diversity of the community).				
	The plan states that easily understandable signage is posted throughout the service area (including, but not limited to diverse languages, minority representation, and responsive to LGBTQ+ (safe space sign), and youth populations).				

Theme 4: Engagement, Continuous Improvement, and Accountability

	Statements	Yes/No	Date of Implementation	Data Source	Responsible Party
CLAS Standard 9: Establish	The plan states that the organization will regularly review organizational planning and operations with the purpose of				

culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.	identifying cultural and linguistic needs that are not being met.				
	The plan states how the annual organizational diversity goals will be created and discussed in meetings throughout the year.				
	The plan states that cultural and linguistic goals created by the organization will be included in the strategic plan and will regularly be included as agenda items in staff meetings.				
CLAS Standard 10: Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and CQI activities.	The plan ensures that there is an ongoing evaluation of CLAS standards and how they are implemented within the organization.				
	The plan states that all staff are provided with CLAS-oriented feedback in their performance reviews.				
	The plan states how often CLAS standards are evaluated and revisited for quality improvement.				
CLAS Standard 11: Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.	The plan details how and when demographic data will be obtained from the target community, and where the information will be updated and posted within the organization.				
	The plan discusses how the community demographic data will be used in program planning and service delivery.				
	The plan discusses how the community demographic data will be used to guide translated material and signage in the organization.				
	The plan discusses how the community demographic data will highlight any apparent disparities that may exist.				
	The plan states that the community demographic data and disparities will be presented to the governance and leadership of the organization annually.				
CLAS Standard 12:	The plan details how and when community health assets and needs are				

Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.	performed.				
	The plan will discuss when and if qualitative data will be collected and used (such as focus groups or interviews) to enhance the community health assets and needs.				
	The plan discusses how findings from the community health needs assessments are utilized within the organization.				
	The plan offers opportunities for collaboration with other community based partners and stakeholders in discussing assets and challenges of the community and sharing best practices related to: 1) meeting needs; 2) capturing community demographics; and 3) strategies on the dissemination of findings.				
	The plan discusses how findings from the community health needs assessments are used in program development.				
CLAS Standard 13: Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.	The plan details the method of targeting and communicating with other community based organizations that offer services that clients would benefit from.				
	The plan recognizes the success of cross-system collaborative efforts and the use of multidisciplinary teams in working with children and families.				
	The plan states the organization's policies on ensuring collaborative agencies practice culturally and linguistically appropriate services and adhere to the CLAS standards.				
CLAS Standard 14: Create conflict and grievance resolution processes that are culturally and linguistically	The plan states the organization's strategies for LEP and others with communication needs to fill out conflict and/or grievances with the organization.				
	The plan offers conflict and grievance forms in various languages, including all of the languages that are represented within the target community.				
	The plan details the grievance resolution process, and the maximum length of				

appropriate to identify, prevent, and resolve conflicts or complaints.	time that grievances will be addressed.				
CLAS Standard 15: Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public.	The plan details where the organization's diversity and linguistic policies are posted for the public.				
	The plan specifies that information collected from stakeholders is used in training, meetings, and for quality improvement.				
	The plan states the organization's policies on open communication to raise concerns of cultural and linguistic needs.				
	The plan states the protocol for a clear communication plan that is discussed with the individual seeking behavioral health care services and their family during discharge.				

Suggested Themes 5 and 6

	Statements	Yes/No	Date of Implementation	Data Source	Responsible Party
Family Acknowledgement	The plan states the organization's policy for including family in the service delivery, including the treatment and discharge of the client.				
	The plan details the organization's efforts and strategies towards coordinated, individualized, family-driven and youth guided services.				
	The plan should detail how the organization identifies familial preferences for and availability of traditional healers, religious and spiritual resources, alternative or complementary healing practices, natural supports, bilingual services, self-help groups, and consultation from culturally and linguistically competent independent providers, except when clinically or culturally contraindicated.				
	The plan acknowledges that treatment plans do not always match family values, and that improved listening to family and youth is suggested.				

Spiritual and Cultural Beliefs in Treatment & Discharge	The plan states that cultural and spiritual beliefs are recognized during the intake assessment.				
	The plan states that cultural and spiritual beliefs are recognized during the service treatment.				
	The plan states that cultural and spiritual beliefs are recognized during discharge of the individual.				
	The plan recognizes that traditional and natural supports may be necessary for treatment and interactions with individuals seeking behavioral health care.				

CLAS STANDARDS SOURCE: https://www.thinkculturalhealth.hhs.gov/

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XLVI. Minimum Accreditation Standards

As part of a statewide initiative to promote the highest standards of quality, ethics, effectiveness, and accountability in nonprofit mental health and substance use services, BBHC is requiring that all its network providers obtain and maintain national accreditation through any of the associations below:

- Council on Accreditation (COA)
- Commission on Accreditation of Rehabilitation Facilities (CARF)
- Joint Commission (JAHCO)
- Council on Accreditation of Peer Recovery Support Services (CAPRSS)

Annually or as appropriate:

- All currently accredited agencies must submit evidence of accreditation with expiration dates.
- Agencies not currently accredited must submit a plan to obtain accreditation with timelines, associated fees, and any concerns/barriers. These agencies must start the accreditation process, as appropriate.
- All Agencies must comply, at a minimum, with accreditation standards of a designated accreditation body, if not accredited.

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XLVII. Performance Measures - CQI Programs

The Provider shall track by Program, as applicable, the following performance measures and report as part of its Quality Assurance ("QA")/Quality Improvement ("QI"). This information shall be made available to BBHC upon request.

Mental Health Services (Admission type):

Covered Services

01-Assessment	19- Residential Level 2
03- Crisis Stabilization Unit	20- Residential Level 3
06 Day/Night	21 Residential Level 4
08- In Home/ On-Site	34- FACT
09-Inpatient	35- Outpatient Group
12-Medical Services (psychiatric)	39-Short-term Residential Treatment
14-Outpatient Individual	Miscellaneous - Peer Support Services
18- Residential Level 1	

A. Average number of calendar days between a request for service and the date of the initially scheduled face-to-face appointment, tracked by intake, assessment, counseling/psychotherapy and psychiatric appointments.

B. Percent of clients who do not appear for their initial appointment tracked by intake, assessments, counseling/psychotherapy and psychiatric appointments.

C. Percent of appointments cancelled by the client tracked for all initial appointments by intake, assessments, counseling/psychotherapy and psychiatric services.

D. Percent of appointments cancelled by the staff for all initial appointments for intake, assessment, counseling/psychotherapy and psychiatric services.

E. When funded for Medical Services - Medication error percentage, as documented during the reporting period including: wrong medication, wrong dose or wrong time of administration as reported in inpatient/CSU and residential settings.

XLVIII. Forms (For form refer to BBHC Website: http://www.bbhcflorida.org/)

- Outreach / Prevention Activities Service Log
- National Voter Registration Monthly Report
- TANF Program Participant Log
- TANF Incidental Request Form
- TANF Monthly Income Verification
- Incidental Fund Invoice and Expenditure Log

NOTE: The DCF Guidance Documents are incorporated herein by reference and may be found on DCF's website: https://www.myflfamilies.com/service-programs/samh/managing-entities/2022-contract-docs.shtml

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XLIX. Trauma-Informed Transformation Initiative

Goal: To assist the agency members of the Broward County Behavioral Health Coalition in creating a trauma- informed and trauma-responsive system of care.

Rationale: With the increased awareness of the impact of stress, adversity, and trauma on people's lives, professionals are considering what this means in their specific settings. There is a growing evidence-base documenting the impact of child neglect and abuse (as well as other forms of traumatic stress) on the health, mental health, and behavior of men and women. While research and clinical experience indicate a high incidence of trauma and co-occurring problems, professionals often struggle with the realities of providing effective management and services.

This is particularly challenging when many agencies have staff impacted by trauma in their personal and work lives. In addition, many settings struggle with organizational stress and trauma, which creates additional challenges in the environment and culture of the workplace.

Today the language "trauma informed" is common in many settings. The process of moving from trauma informed to trauma responsive in order to implement trauma-informed care (TIC) is often challenging to administrators and staff.

Strategy: Creating organizational change in a large, complex, and multi-tiered system requires a structured multi- layered process. Historically, large scale organizational change is estimated to be a three-year to five- year process. Success is heavily influenced by the support of visionary leadership.

Work Plan: With 74 programs/agencies (staff total is 3073, ranging from 1 staff member to 695), we recommend working in cohort groups with our Certified Trainer/Consultant, Eileen Russo. Cohorts of 10 programs/agencies would be launched at staggered times with some cohorts with more than 10 (smaller programs). The plan would be to have 6-7 cohorts with one started every 3 months. The following timeline is for each cohort.

Timeline		
Month	**Activity**	**Who**
1	Kick-off • Definitions • Brief overview of trauma • Brief overview of vicarious trauma and compassion fatigue • Overview of Guide Team (GT) development • Overview of 5 core values.	Eileen/Zoom producer and as many staff as possible from the cohort
1	Develop Guide Teams (each agency)	Sites
2	Guide Team begins meeting at least monthly	Sites
2	Schedule virtual site visit	Sites and Eileen
3	Review of policies, program materials recommendations	Eileen
3-4	Written recommendations returned to each site	

3	Initial implementation plan developed	Sites- GT
3	Training (Trauma 101, Importance of Staff Care) (Length of time determined by existing knowledge base, usually done in 2 sessions)	Eileen/Zoom producer and as many staff as possible from the cohort
4	Cohort meeting #1 with guide teams of all agencies	Eileen
5	GT continues to meet and add to and work on items identified in the plan	Sites
6	GT continues to meet and add to and work on items identified in the plan	Sites
7	GT continues to meet and add to and work on items identified in the plan	Sites
Individual consultations scheduled during months 5, 6, and 7 (Once per agency)		Eileen and agency GTs
8	Cohort meeting #2 with guide teams from each agency	Eileen
9	GT continues to meet and add to and work on items identified in the plan	Sites
10	GT continues to meet and add to and work on items identified in the plan	Sites
11	GT continues to meet and add to and work on items identified in the plan	Sites
12	Cohort meeting #3 with all agency guide teams	Eileen
Individual consultations scheduled during months 10, 11, and 12 (once per agency)		Eileen and agency GTs
13	GT continues to meet and add to and work on items identified in the plan	Sites
14	GT continues to meet and add to and work on items identified in the plan	Sites
15	GT continues to meet and add to and work on items identified in the plan	Sites
16	GT continues to meet and add to and work on items identified in the plan	Sites
17	GT continues to meet and add to and work on items identified in the plan	Sites
Individual consultations scheduled during months 15, 16, and 17 (once per agency)		Eileen and agency GTs
18	Cohort meeting-Celebration!	Everyone!
Optional Add-Ons		
Month	**Activity**	**Who**
Other	Optional- each agency is able to request spontaneous consultation to answer questions, help with stuck points	
Other	Optional-conduct staff focus group, client focus group	

10 agencies, 9:30-12:30 pm (ET) via zoom:

The purpose of the kick-off is to begin to acclimate each cohort to the process of becoming trauma- informed/responsive. The topics will include:

- Definitions of trauma-informed, trauma-responsive, and trauma-specific
- Brief overview of trauma
- Brief overview of vicarious trauma and compassion fatigue
- Overview of 5 core values
- Overview of Guide Team (GT) development
- Next steps

Who should attend?

- Up to 10-12 people per agency
- Those attending should represent various roles across the agency, but not all of those attending should be management/supervisors

Creating a Guide Team

The purpose of a guide team is to guide (rather than steer) the process of becoming trauma-informed/responsive. The composition of the guide team is:

- A chair or co-chairs. It is best to not have this be upper management, but the chair (s) should have or be given some authority to make decisions and help implement recommendations.
- Depending on the size of the agency, a guide team is 5-8 people (no more than 10), that represents various roles throughout the agency, but not all management.
- 2 members of the guide should be current or former recipients of services.

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Provider Contract Handbook Updates:

Version	Version Release Date	Sections Updated
4.02	12.22.2020	• Family Engagement Program (FEP) • Family Intensive Treatment Team (FITT) • Care Coordination Team –Child Welfare (CW) • Community Action Team (CAT) • One Community Partnership 3 (OCP3) • SOAR • PATH • Housing Initiative • Mental Health Respite • Transitional Housing Program
5.01	9.9.2021	• Released FY 21-22
5.02	3.31.2022	• Updated Rates • Added Care Coordination Team –Children •
6.01	8.25.2022	• Released FY 22-23 • Update BNet Rate • FACT • School Behavioral Health Services Program (SBHSP) • Family Connections Through Peer Recovery (Family-CPR) Project
6.02	12.30.2022	• Updated Required Reports Table • Added List of Exhibits • Updated Children Care Coordination Team • Added Family Response Teams
7.01	9.28.2023	• Released FY 23-24 • Add Residential Support Coordination • Updated BNet Rate
7.02	1.29.2024	• Update FEP Section • Add Daycare Rate • Add Trauma-Informed Transformation Initiative

Broward Behavioral Health Coalition, Inc.

EXHIBIT "F"
BBHC DCF CONTRACT

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CONTRACT NO. JH343
AMENDMENT NO. 64

This Amendment shall be effective February 1, 2024, or the last party signature date, whichever is later. The above referenced Contract is hereby amended as follows:

1. The following items were last addressed in the noted Amendments:

Amendment #59: 7
Amendment #62: 6
Amendment #63: 2, 8-10

2. In **1.1, $762,932,344.07** is replaced by **$763,941,743.07.**

3. This contract is extended through December 31, 2024.

4. **A-6.2** is amended as highlighted below. The non-highlighted portions are for contextual purposes only and are unaffected by this amendment.

A-6.2 Dispute Resolution

In addition to the terms of **Section 6.3**, the following Dispute Resolution terms shall apply to this Contract:

A-6.2.1 The parties agree to cooperate in resolving any differences in interpreting the contract. Within five working days of the execution of this contract, each party shall designate one person with the requisite authority to act as its representative for dispute resolution purposes. Each party shall notify the other party of the person's name and business address and telephone number. Within five working days from delivery to the designated representative of the other party of a written request for dispute resolution, the representatives will conduct a face-to-face meeting to resolve the disagreement amicably. If the representatives are unable to reach a mutually satisfactory resolution, either representative may request referral of the issue to the Managing Entity's Chief Executive Officer (CEO) and the Department's Deputy Assistant Secretary for Substance Abuse and Mental Health. Upon referral to this second step, the respective parties shall confer in an attempt to resolve the issue.

A-6.2.2 If the CEO and Deputy Assistant Secretary are unable to resolve the issue within 10 days, the parties' appointed representatives shall meet within 10 working days and select a third representative. These three representatives shall meet within 10 working days to seek resolution of the dispute. If the representatives' good faith efforts to resolve the dispute fail, the representatives shall make written recommendations to the Secretary who will work with both parties to resolve the dispute. The parties reserve all their rights and remedies under Florida law. Venue for any court action will be in Leon County, Florida.

5. **C-1.2** is amended to add:

C-1.2.13 Coordinated Opioid Recovery Network of Addiction Care (CORE Network)

C-1.2.13.1 Reserved.

C-1.2.13.2 No later than 14 days following written notification from the Department of approval of the expansion counties, the Managing Entity shall submit an Implementation Plan to expand the preexisting CORE Network by executing new subcontracts with partners in the counties specified in **Exhibit C2, Table 1a**. Subcontracts shall be executed no later than April 30, 2024.

C-1.2.13.3 The Managing Entity shall implement all CORE Network subcontracts according to the provisions of **Guidance 41,** notwithstanding the provisions of **Sections B-5, C-1.3.2.6, C-2.2.3.2.6, C-2.2.9, or C-2.4.5.**

C-1.2.13.4 The Managing Entity shall implement the data collection process prescribed by the Department and shall make no change to the type, volume, method, and character of data captured under **Guidance 41**, notwithstanding the provisions of **Section C-1.4.4**.

C-1.2.13.5 The Managing Entity shall not require Specialty Subcontractors to formally enroll as a Network Service Provider within the subcontracted Network as a pre-condition to subcontracting within the CORE Network.

6. **C-1.2.12** is replaced by:

C-1.2.12 Florida Opioid Settlement Statewide Response

C-1.2.12.1 The Managing Entity shall implement, administer, monitor, and report on funds appropriated pursuant to the Managing Entity in compliance with the Florida Opioid Allocation and Statewide Response Agreement, executed November 15, 2021, hereby incorporated by reference and supplemental guidance as provided by the Department.

C-1.2.12.2 The provisions of **Sections B-5, C-1.3.2.6, C-2.2.3.2.6, C-2.2.9, and C-2.4.5**. shall not apply to subcontracts or any other form of agreement for projects implementing the above referenced Agreement.

C-1.2.12.3 All subcontracts between the Managing Entity and Opioid Settlement-funded providers shall include the following language in a conspicuous location.

Receipt of Opioid Settlement funds is an express acknowledgement of the obligation to report data on services funded by the Settlement. Recipients shall provide data to the Department of Children and Families (Department) through the Opioid Data Management System (ODMS) as prescribed by the Department. Opioid Settlement funding is contingent upon satisfactory data reporting.

7. The highlighted portion of the table below amends **C2, Table 1a**. The non-highlighted portions are for contextual purposes only and are unaffected by this amendment.

Table 1a Department-Specified Special Projects				
Project	Provider		Amount	Recurring?
PPG Solicitation RFA LHZ03	Hanley Center Foundation, Inc		$147,256.00	Yes FY15-16 through FY17-18
PPG Solicitation RFA 0H17GN1	Hanley Center Foundation, Inc		$147,256.00	Yes FY18-19 through FY20-21
PPG Solicitation RFA11L2GN1	Hanley Center Foundation, Inc. dba Hanley Foundation South Broward Hospital District dba Memorial Healthcare System Gang Alternative, Inc.		1. $150,000.00 2. $147,256.00 3. $150,000.00	Yes FY21-22 through FY23-24
CRS Solicitation RFA 07H16GS2	Henderson Behavioral Health, Inc. Effective 1/1/17 through 12/31/22	FY16-17	$2,086,415.00	Yes FY16-17 through FY20-21
		FY17-18	$2,606,185.00	
		FY18-19 to FY20-21	$4,305,021.00	
		FY21-22	$2,272,642.00	
FEMA DR 4337 FL	Hurricane Irma Disaster Behavioral Health Response FEMA CCP Immediate Response Program		$161,671.40	No
			$1,342,236.00	Yes

Ch. 2018-03, Laws of Florida, Section 48	Mobile Crisis Teams		
CARES Act Allocation Plan	CAT Expansion Memorial Behavioral Health Broward	$250,000.00	No
	NAS/SEN Team 3.0 FTE at provider TBD by ME Priority Location: Circuit 17	$300,000.00	
	Adult Care Coordination 1.0 FTE ME direct staffing	$100,000.00	
	Child Care Coordination 1.0 FTE ME direct staffing	$100,000.00	
	Child Care Coordination 3.0 FTE provider staffing TBD by ME	$300,000.00	
	Wraparound Training Expansion ME operational cost	$10,000.00	
	211 Expansion First Call for Help of Broward, Inc. dba 2-1-1 Broward	$83,334.00	
FL 2-1-1 Network	First Call for Help of Broward, Inc. dba 2-1-1 Broward	$250,000.00	Yes
FEMA DR 4673FL	Hurricane Ian Disaster Behavioral Health Response – FEMA CCP Immediate Services Program – cost reimbursement invoicing	$75,000	No
FY22-23 Recurring Lump Sum Allocation	High Acuity Team, also referred to as a FACT Tier 4 variation, implemented according to a program description on file with the contract manager.	$923,000	Yes
Coordinated Opioid Recovery (CORE) Network	Expansion CORE Projects **1.** Broward	$1,000,000.00	No

8. The highlighted portions below amend **F-1.2, Table 7**. The non-highlighted portions are for contextual purposes only and are unaffected by this amendment.

Table 7 – Contract Funding

State Fiscal Year	Managing Entity Operational Cost	Direct Services Cost	Supplemental DBH Funds	Total Value of Contract
2010-2011	$	$	$	$
2011-2012	$	$	$	$
2012-2013	$1,642,303.68	$28,436,518.39	$	$30,078,822.07
2013-2014	$2,285,924.00	$43,857,573.00	$	$46,143,497.00
2014-2015	$2,304,258.26	$44,246,413.74	$	$46,550,672.00
2015-2016	$2,298,027.15	$48,769,242.85	$	$51,067,270.00
2016-2017	$2,657,237.00	$51,122,907.00	$	$53,780,144.00
2017-2018	$2,676,785.00	$55,137,143.00	$161,671.00	$57,975,599.00
2018-2019	$2,646,718.00	$60,107,395.00	$	$62,754,113.00
2019-2020	$2,985,875.00	$63,477,652.00	$	$66,463,527.00
2020-2021	$3,134,208.00	$64,849,438.00	$	$68,013,646.00
2021-2022	$3,522,816.00	$74,816,100.00	$	$78,338,916.00
2022-2023	$5,081,683.00	$94,486,352.00	$75,000.00	$99,964,035.00
2023-2024	$4,953,646.00	$98,178,856.00	$	$103,132,502.00
Total	**$36,219,481.09**	**$727,485,590.98**	**$236,671.00**	**$763,941,743.07**

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9. **Exhibit F1** is replaced by the attached **Exhibit F1**.

10. The highlighted portions below amend **F2-1, Table 8**. The non-highlighted portions are for contextual purposes only and are unaffected by this amendment.

Table 8 - Schedule of Payments for Fiscal Year 2023-2024

Month of Services	FY Contract Balance Prior to Payment	Fixed Payment Amount	FY Contract Balance after this Payment	Invoice Packet Due Date	Progress and Expenditure Report Period
Initial Advance	$70,913,004.00	$11,818,834.00	$59,094,170.00	7/1/23	N/A
Supp Advance	$25,362,002.00	$4,227,000.33	$21,135,001,67	7/31/2023	N/A
Total Advance	$96,275,006.00	$16,045,834.33	$80,229,171.67		
July 2023	$80,229,171.67	$6,685,764.30	$73,543,407.37	8/20/23	July
August 2023	$73,543,407.37	$6,685,764.30	$66,857,643.07	9/20/23	August
September 2023	$66,857,643.07	$6,685,764.30	$60,171,878.77	10/20/23	September
October 2023	$60,171,878.77	$6,685,764.30	$53,486,114.47	11/20/23	October
November 2023	$59,334,211.47	$7,416,776.43	$51,917,435.04	12/20/23	November
December 2023	$51,917,435.04	$7,416,776.43	$44,500,658.61	1/20/24	December
January 2024	$44,500,658.61	$7,416,776.43	$37,083,882.18	2/20/24	January
February 2024	$38,093,281.18	$7,618,656.24	$30,474,624.94	3/20/24	February
March 2024	$30,474,624.94	$7,618,656.24	$22,855,968.70	4/20/24	March
April 2024	$22,855,968.70	$7,618,656.24	$15,237,312.46	5/20/24	April
May 2024	$15,237,312.46	$7,618,656.24	$7,618,656.22	6/20/24	May
June 2024	$7,618,656.22	$7,618,656.22		8/15/24	June
Total FY Payments		**$103,132,502**			

11. All provisions in the Contract and any attachments thereto in conflict with this Amendment are changed to conform with this Amendment. All provisions not in conflict with this Amendment are still in effect and are to be performed at the level specified in the Contract. This Amendment and all its attachments are made a part of the Contract.

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IN WITNESS THEREOF, the parties hereto have caused this Amendment executed by their undersigned officials as duly authorized.

PROVIDER

Signature: Julie F. Klahr

Name: Julie F. Klahr

Title: General Counsel

Date: 2/2/2024 | 3:00 PM EST

DEPARTMENT

Signature: Shevaun L. Harris

Name: Shevaun L. Harris

Title: Secretary

Date: 2/5/2024 | 8:01 AM EST

PROVIDER

Signature: Nan Rich

Name: Nan Rich

Title: Board Chair

Date: 2/3/2024 | 12:04 PM EST

Exhibit F1 - ME Schedule of Funds
Broward Behavioral Health - Contract# JH343
FY 2023-24 Use Designation - As of 1/3/2024

Other Cost Accumulators Title	Line #	GAA Category	Other Cost Accumulators (OCA)	Federal	State	Total	The Amount of Non-Recurring Funds included in Total Amount
Managing Entity Operational Cost							
ME Administrative Cost	373/386	100610/106220	MHS00	24,671	2,557,448	2,582,119	
ME MH Broward Stepping Up Jail Diversion Operational	378	100778	MHBJO	-	100,000	100,000	100,000
ME Care Coordination MHBG Supplemental 2 Federal Budget Period: 9/1/2021 - 9/30/2025	383	105153	MHCM3	600,000	-	600,000	600,000
ME MH Individual Placement & Support Train-BG Supplemental 2 Federal Budget Period: 9/1/2021 - 9/30/2025	383	105153	MHIP2	-	-	-	
ME FL System of Care - Admin - Year 2	378	100778	MHSCB	-	-	-	
ME FL System of Care - Admin - Year 3	378	100778	MHSA3	-	-	-	
ME Care Coordination	378	100778	MHSCD	-	904,875	904,875	
ME Operational MHBG Supplemental 2 Federal Budget Period: 9/1/2021 - 9/30/2025	383	105153	MHSM2	59,803	-	59,803	59,803
ME Operational SAPT Supplemental 2 Federal Budget Period: 9/1/2021 - 9/30/2025	383	105153	MHSS2	100,795	-	100,795	100,795
ME SA McKinsey Settlement - ME Care Coordination	380A	102400	MS923	-	394,277	394,277	394,277
ME State Opioid Response Disc Grant Admin - Year 4	386	106220	MSSA4	29,407	-	29,407	29,407
ME State Opioid Response Disc Grant Admin - Year 5	386	106220	MSSA5	45,586	-	45,586	45,586
ME State Opioid Response Disc Grant Admin - Year 6	386	106220	MSSA6	136,784	-	136,784	136,784
Total Operational Cost				**997,046**	**3,956,600**	**4,953,646**	**1,466,652**
Direct Services Cost							
Mental Health Core Services Funding							
ME Mental Health Services & Support	373/374/377/378	100610/100611/100777/100778	MH000	4,183,471	21,488,426	25,671,897	597,971
ME MH Services MHBG Supplemental 2 Federal Budget Period: 9/1/2021 - 9/30/2025	383	105153	MHARP	1,614,950	-	1,614,950	1,614,950
ME Early Intervention Services-Psychotic Disorders	373	100610	MH026	750,000	-	750,000	
ME BSCA Early Intervention SVC-Psychotic Disorders	373	100610	MH26B	49,450	-	49,450	49,450
ME MH Citrus Health Network	373	100610	MH094	-	-	-	
ME MH BSCA 988 Suicide and Crisis Lifeline	373	100610	MHCBS	169,231	-	169,231	169,231
ME MH Forensic Transitional Beds	373	100610	MHFMH	-	1,401,600	1,401,600	
ME MH State Funded Federal Excluded Services	373/374	100610/100611	MHSFP	-	3,987,608	3,987,608	
ME MH Transitional Beds for MH Institution	373	100610	MHTMH	-	-	-	
Total Mental Health Core Services Funding				**6,767,102**	**26,877,634**	**33,644,736**	**2,431,602**
Mental Health Discretionary Grants Funding							
ME MH 988 State and Territory Improvement Grant	373	100610	MH981	374,995	-	374,995	374,995
ME MH 988 Implementation Fed Discretionary Grant	373	100610	MH98G	245,663	-	245,663	132,664
ME FL SOC Expansion & Sustain Project -Year 2	373	100610	MHSC2	-	-	-	
ME FL SOC Expansion & Sustain Project -Year 3	373	100610	MHSC3	-	-	-	
Total Mental Health Discretionary Grants Funding				**620,658**	**-**	**620,658**	**507,659**
Mental Health Proviso Projects Funding							
ME Stewart-Marchman Behavioral Healthcare	387	108850	MH011	-	-	-	
ME MH Personal Enrichment MH CSU	378	100778	MH016	-	-	-	
ME SFBN Involuntary Outpatient Services Pilot Project	378	100778	MH021	-	-	-	
ME Directions for Living	378	100778	MH027	-	-	-	
ME David Lawrence Center	378	100778	MH031	-	-	-	
ME Veterans and Families Pilot Program	378	100778	MH032	-	-	-	
ME MH UF Health Center for Psychiatry	378	100778	MH034	-	-	-	
ME MH LifeStream Central Receiving System-Citrus County	378	100778	MH035	-	-	-	
ME Fort Myers Salvation Army	378	100778	MH037	-	-	-	
ME MH NW Behavioral Hlth SVCS-Training Trauma Now	378	100778	MH048	-	-	-	
ME MH Okaloosa/Walton MH & SA Pretrial Diversion Project	378	100778	MH051	-	-	-	
ME Veterans Alternative Retreat Program	378	100778	MH060	-	-	-	
ME MH Starting Point Behavioral Health Care Project Talks	378	100778	MH063	-	-	-	
ME Peace River Center Sheriffs Outreach Program	378	100778	MH066	-	-	-	
ME MH Indian River-MHA-Walk In Counseling Center	378	100778	MH068	-	-	-	
ME MH Marion CO Law Enforcement CO Respond Program	378	100778	MH069	-	-	-	
ME MH Faulk Center Behind the Mask MH Services	378	100778	MH070	-	-	-	
ME Clay Behavioral Health-Crisis Prevention	378	100778	MH089	-	-	-	
ME MH Forensic Residential Stepdown	378	100778	MH100	-	-	-	
ME MH AGAPE Network Community Reentry	378	100778	MH101	-	-	-	
ME MH Alpert Jewish Family Services Disabilities	378	100778	MH102	-	-	-	
ME MH Peace River Center IT and Cyber Security	378	100778	MH103	-	-	-	
ME MH Ruth Norman Rales Jewish Family SVCS Psych	378	100778	MH104	-	-	-	
ME MH Center for Child Counseling MH Services	378	100778	MH105	-	-	-	
ME MH Centerstone Sarasota Comp TRTMT Court	378	100778	MH106	-	-	-	
ME MH Centerstone Manatee Receiving System	378	100778	MH107	-	-	-	
ME MH CFBHN Hillsborough Short Term Residential	378	100778	MH108	-	-	-	
ME Charlotte Behavioral Health Central Recv Fac	378	100778	MH109	-	-	-	
ME MH El-Beth-El Development Center Youth Crime	378	100778	MH111	-	-	-	
ME MH Joe DiMaggio Child Hospital At-Risk Youth	378	100778	MH114	-	500,000	500,000	500,000
ME MH Life Builders of Treasure Coast	378	100778	MH115	-	-	-	
ME MH Lifetime Counseling CTR Behavioral Health	378	100778	MH116	-	-	-	
ME MH LJD Jewish Family Community Services	378	100778	MH117	-	-	-	
ME MH Association of Central FL MH SVCS Uninsured	378	100778	MH118	-	-	-	
ME MH Miami Dade Homeless Trust Proj Lazarus	378	100778	MH119	-	-	-	
ME MH Nami Jacksonville Family & Peer Support	378	100778	MH120	-	-	-	
ME MH Nami Sarasota & Manatee family Peer Nav	378	100778	MH121	-	-	-	
ME MH Nonies Place Child Therapy CTR Escambia	378	100778	MH122	-	-	-	
ME MH Project Lift Treatment and Workforce Dev	378	100778	MH124	-	-	-	
ME MH Citrus Health network ACS	378	100778	MH128	-	-	-	
ME Hillsborough CSU	378	100778	MH819	-	-	-	
Aspire Health Partners Veterans National Guard MH Services	378	100778	MHASP	-	-	-	
ME MH Broward Stepping Up Jail Diversion	378	100778	MHBJD	-	410,400	410,400	410,400
ME MH Flagler Brave Program	378	100778	MHBRV	-	-	-	
ME MH Connect Familias MH Youth Screen	378	100778	MHCFY	-	-	-	
ME MH Eagles Haven Wellness Center	378	100778	MHEHW	-	600,000	600,000	600,000
ME MH FL Recovery Schools Tampa Bay	378	100778	MHFRS	-	-	-	
ME MH Alpert Jewish Family Support Line	378	100778	MHFSL	-	-	-	
ME MH First Step Sarasota CSU & Detox Center	378	100778	MHFSS	-	-	-	
ME MH Here Tomorrow Outpatient MH Services	378	100778	MHHTO	-	-	-	
ME MH JCS Miami Dade Monroe Crisis Line	378	100778	MHJCL	-	-	-	
ME MH Jewish Family Services Collaboration	378	100778	MHJFS	-	-	-	
ME MH LMC Forensic Multidisciplinary Team	378	100778	MHLFH	-	-	-	
ME MH Life Management Center Functional Family Therapy Team	378	100778	MHLFT	-	-	-	
ME Renaissance Manor	378	100778	MHRM5	-	-	-	
ME LifeStream Center	378	100778	MHS50	-	-	-	
ME MH Senior MH Wellness $ Crisis Response Line	378	100778	MHSWL	-	-	-	
ME MH Centerstone Trauma Recovery Center	378	100778	MHTRM	-	-	-	
Total Mental Health Proviso Projects Funding				**-**	**1,510,400**	**1,510,400**	**1,510,400**

Mental Health Targeted Services Funding							
ME MH Purchase of Residential Treatment Services for Emotionally Disturbed Children and Youth	381	102780	MH071	-	150,762	150,762	
ME MH Community Forensic Beds	373	100610	MH072	-	653,466	653,466	
ME MH Indigent Psychiatric Medication Program	380	101350	MH076	-	74,817	74,817	
ME MH BNET (Behavioral Health Network)	373	100610	MH0BN	811,390	-	811,390	
ME MH Care Coordination Direct Client Services	373	100610	MH0CN	-	1,003,056	1,003,056	
ME Community Forensic Multidisciplinary Teams	373	100610	MH0FH	-	652,000	652,000	
ME FACT Medicaid Ineligible	387	108850	MH0FT	117,154	764,800	881,954	
ME MH PATH Grant	373	100610	MH0PG	379,990	-	379,990	
ME MH Temporary Assistance for Needy Families (TANF)	373	100610	MH0TB	769,532	-	769,532	
ME Expanding 211 Call Vol & Coordination Initiative	373	100610	MH211	-	250,000	250,000	
ME MH Early Intervention Services MHBG Supplemental 2 Federal Budget Period: 9/1/2021 - 9/30/2025	383	105153	MH262	750,000	-	750,000	750,000
ME MH 988 Implementation Federal Budget Period: 9/1/2021 - 9/30/2025	383	105153	MH988	635,272	-	635,272	635,272
ME MH Alpert Family Services - Mental Health First Aid Coalition	378	100778	MHAJF	-	-	-	
ME MH Community Action Treatment (CAT) Teams	372/373	100425/100610	MHCAT	-	1,500,000	1,500,000	
ME Core Crisis Set Aside MHBG Supplemental 2 Federal Budget Period: 9/1/2021 - 9/30/2025	383	105153	MHCC2	161,806	-	161,806	161,806
ME MH Forensic Community Diversion MHBG Supplemental 2 Federal Budget Period: 9/1/2021 - 9/30/2025	383	105153	MHCJ4	-	-	-	
ME Disability Rights Florida Mental Health	373	100610	MHDRF	-	144,000	144,000	
ME MH Evidence Based Practice Team	373	100610	MHEBP	-	-	-	
ME MH Early Diversion of Forensic Individuals	373	100610	MHEDT	-	-	-	
ME MH Supported Employment Services	373	100610	MHEMP	-	150,000	150,000	
ME MH Mobile Crisis Teams	373	100610	MHMCT	172,746	1,273,488	1,446,234	87,882
MH ME Other Multidisciplinary Team	373	100610	MHMDT	-	1,640,420	1,640,420	
ME Suicide Prevention MHBG Supplemental 2 Federal Budget Period: 9/1/2021 - 9/30/2025	383	105153	MHPV2	300,000	-	300,000	300,000
ME MH Residential Stability Coordination MHBG Supplemental 2 Federal Budget Period: 9/1/2021 - 9/30/2025	383	105153	MHRE2	133,750	-	133,750	133,750
ME Centralized Receiving Systems	376	100621	MHSCR	-	4,305,021	4,305,021	
ME Sunrise / Sunset Beds Pilot	378	100610	MHSUN	-	-	-	
ME MH Telehealth Behavioral Health Services	378	100778	MHTLH	-	-	-	
ME Transitions Vouchers Mental Health	373	100610	MHTRV	-	147,994	147,994	
Total Mental Health Targeted Services Funding				**4,231,640**	**12,709,824**	**16,941,464**	**2,068,710**
Subtotal Mental Health				**11,619,400**	**41,097,858**	**52,717,258**	**6,518,371**
Substance Abuse Core Services							
ME Substance Abuse Services and Support	375/377	100618/100777	MS000	7,853,489	6,813,750	14,667,239	599,427
ME SA Services SAPT Supplemental 2 Federal Budget Period: 9/1/2021 - 9/30/2025	383	105153	MSARP	4,514,031	-	4,514,031	4,514,031
ME SA HIV Services	375	100618	MS023	583,580	-	583,580	132,797
ME SA Prevention Services	375	100618	MS025	2,334,317	-	2,334,317	531,187
ME SA Cove Behavioral Health	375	100618	MS095	-	-	-	
ME Here's Help	375	100618	MS903	-	-	-	
ME SA St. Johns County Sheriff's Office-Detox Program	375	100618	MS907	-	-	-	
ME SA State Funded Federal Excluded Services	375	100618	MSSFP	-	2,196,194	2,196,194	
Total Core Services Funding				**15,285,417**	**9,009,944**	**24,295,361**	**5,777,442**
Substance Abuse Discretionary Grants							
ME SA Prevention Partnership Program	375	100618	MS0PP	147,256	-	147,256	
ME State Opioid Response Disc - Rec Comm Org - Year 4	375	100618	MSRC4	50,000	-	50,000	50,000
ME State Opioid Response Disc - Rec Comm Org - Year 5	375	100618	MSRC5	87,500	-	87,500	87,500
ME State Opioid Response Disc - Rec Comm Org - Year 6	375	100618	MSRC6	262,500	-	262,500	262,500
ME State Opioid Response SVCS-MAT - Year 4	375	100618	MSSM4	369,306	-	369,306	369,306
ME State Opioid Response SVCS-MAT - Year 5	375	100618	MSSM5	1,473,928	-	1,473,928	1,473,928
ME State Opioid Response SVCS-MAT - Year 6	375	100618	MSSM6	4,688,053	-	4,688,053	4,688,053
ME State Opioid Response Disc Grant SVCS-Prevention - Year 4	375	100618	MSSP4	50,000	-	50,000	50,000
ME State Opioid Response Disc Grant SVCS-Prevention - Year 5	375	100618	MSSP5	87,500	-	87,500	87,500
ME State Opioid Response Disc Grant SVCS-Prevention - Year 6	375	100618	MSSP6	262,500	-	262,500	262,500
Total Discretionary Grants Funding				**7,478,543**	**-**	**7,478,543**	**7,331,287**
Substance Abuse Proviso Projects							
ME SA Aware Recovery Care Rural Florida	378	100778	MS100	-	-	-	
ME SA Live Tampa Bay Bridges Not Barriers Pilot	378	100778	MS101	-	-	-	
ME SA Recovery Connection Central FL Help People	378	100778	MS105	-	-	-	
ME Memorial Healthcare-Medication Assisted Treatment Program	378	100778	MS912	-	1,000,000	1,000,000	1,000,000
ME SA Gateway Community Services-Saving Lives Project	378	100778	MS916	-	-	-	
ME Specialized Treatment, Education and Prevention Services-Women's Residential Treatment	378	100778	MS917	-	-	-	
ME SA St. Johns Epic Recovery Center-Women's Residential Bed	378	100778	MS918	-	-	-	
ME SA Here's Help-Juvenile Resident Treatment Expansion	378	100778	MS921	-	-	-	
ME MS Broward Health-Integrated Medication Assisted Treatment	378	100778	MS922	-	999,238	999,238	999,238
ME SA Change Everything Init. Opioid Crisis Pilot	378	100778	MSCEI	-	-	-	
ME SA Seminole County Sheriff Opioid ARC Partnership	378	100778	MSCS0	-	-	-	
ME SA Long Acting Inject Buprenorphine Pilot PGM	378	100778	MSLAB	-	375,000	375,000	375,000
Total Proviso Projects Funding				**-**	**2,374,238**	**2,374,238**	**2,374,238**
Substance Abuse Targeted Services							
ME Expanded SA Services for Pregnant Women, Mothers and Their Families	375	100618	MS081	-	1,043,188	1,043,188	
ME SA Family Intensive Treatment (FIT)	375	100618	MS091	-	800,000	800,000	
ME SA Care Coordination Direct Client Services	375	100618	MS0CN	-	151,738	151,738	
ME SA Temporary Assistance for Needy Families (TANF)	375	100618	MS0TB	543,371	-	543,371	
ME Primary Prevention SAPT Supplemental 2 Federal Budget Period: 9/1/2021 - 9/30/2025	383	105153	MS252	853,697	-	853,697	853,697
ME McKinsey Settlement-SA Services	380A	102400	MS925	-	510,663	510,663	510,663
ME SA Community Based Services	375	100618	MSCBS	-	1,428,616	1,428,616	
ME NES/SEN Care Coordination SAPT Supplemental 2 Federal Budget Period: 9/1/2021 - 9/30/2025	383	105153	MSCS3	600,000	-	600,000	600,000
ME Opioid TF Coord Opioid Recovery Care	375	100618	MSOCR	-	1,000,000	1,000,000	1,000,000
ME Opioid TF Hospital Bridge Programs	375	100618	MSOHB	-	360,658	360,658	180,329
ME Opioid TF Non-Qualified Counties	375	100618	MSONQ	-	-	-	
ME Opioid TF Peer Supports and Recovery Comm Org	375	100618	MSOPR	-	1,172,137	1,172,137	991,809
ME Opioid TF Treatment and Recovery	375	100618	MSOTR	-	1,803,288	1,803,288	450,822
ME SA Prevention Partnership Program SAPT Supplemental 2 Federal Budget Period: 9/1/2021 - 9/30/2025	383	105153	MSPP2	300,000	-	300,000	300,000
ME Suicide Prevention SAPT Supplemental 2 Federal Budget Period: 9/1/2021 - 9/30/2025	383	105153	MSPV2	200,000	-	200,000	200,000
ME Transitions Vouchers Substance Abuse	375	100618	MSTRV	-	96,100	96,100	
ME Transitional Vouchers SAPT Supplemental 2 Federal Budget Period: 9/1/2021 - 9/30/2025	383	105153	MSTV2	450,000	-	450,000	450,000
Total Targeted Services Funding				**2,947,068**	**8,366,388**	**11,313,456**	**5,537,320**
Subtotal Substance Abuse				**25,711,028**	**19,750,570**	**45,461,598**	**21,020,287**
Total All Fund Sources				**38,327,474**	**64,805,028**	**103,132,502**	**29,005,310**
Supplemental Disaster Behavioral Health (DBH) Response Funds							
ME Hurricane Idalia Crisis Counseling ISP	373	100610	MHHID	-	-	-	
ME Hurricane Ian Crisis Counseling RSP	373	100610	MHRSP	-	-	-	
ME HQ Hurricane IAN Crisis Counsel RSP Services Operational	386	106220	MHSIR	-	-	-	
Total DBH Response Funds				**-**	**-**	**-**	**-**
Total FY Contract Amount				**38,327,474**	**64,805,028**	**103,132,502**	**29,005,310**

AMENDMENT #0038
(AMENDMENT, RESTATEMENT)

THIS AMENDMENT, entered into between the State of Florida, Department of Children and Families, hereinafter referred to as the "Department" and **Broward Behavioral Health Coalition, Inc.**, hereinafter referred to as the "Provider," amends **Contract #JH343.**

Amendment #0037, executed 6/17/2019, renewed Contract #JH343 for an additional five (5) years through June 30, 2024, pursuant to F.S. 394.9082(4)(j) and (6)(a) and amend Exhibits F and F2. There will be no further renewals.

The purpose of Amendment #0038 is to incorporate the CF Standard Contract 2019, Parts 1 and 2, the revised Exhibits A-F2, Attachments 1-3, and the Schedule of Funds as of 7/1/2019 for Fiscal Year 2019-2020.

1. **Pages 1-17, CF Standard Contract 2018, Part 1 of 2, as previously amended by Amendments #0033- #0037, are hereby deleted in their entirety and Pages 1-17, CF Standard Contract 2019, Part 1 of 2, are hereby inserted in lieu thereof and attached hereto.**
2. **The replacement of page 8 of the CF Standard Contract 06/2012 (Original Contract) and page 17 of the CF Standard Contract 2018, Part 1 of 2, does not affect the original execution date of this contract.**
3. **Pages 18-77, CF Standard Contract 2018, Part 2 of 2, REVISED EXHIBITS A–F2, as previously amended by Amendments #0033-0037, are hereby deleted in their entirety and Pages 18-81, CF Standard Contract 2019, Part 2 of 2, EXHIBITS A-F2, are hereby inserted in lieu thereof and attached hereto.**
4. **Pages 77-79, ATTACHMENT 1, FINANCIAL AND COMPLIANCE AUDIT ATTACHMENT, April 2016, are hereby deleted in their entirety and Pages 82-84, ATTACHMENT 1, FINANCIAL AND COMPLIANCE AUDIT ATTACHMENT, February 2017, are hereby inserted in lieu thereof and attached hereto.**
5. **Pages 80-84, ATTACHMENT 2, PROVIDER'S ACCESS TO AND USE OF PROTECTED HEALTH INFORMATION, are hereby deleted in their entirety and Pages 85-89, ATTACHMENT 2, PROVIDER'S ACCESS TO AND USE OF PROTECTED HEALTH INFORMATION, are hereby inserted in lieu thereof and attached hereto.**
6. **Page 86, ATTACHMENT 3, CERTIFICATION REGARDING LOBBYING, is hereby deleted in its entirety and Page 90, ATTACHMENT 3, CERTIFICATION REGARDING LOBBYING, is hereby inserted in lieu thereof and attached hereto.**

AMENDMENT #0038 Contract #JH343

This amendment shall begin on August 1, 2019 or the date on which the amendment has been signed by both parties, whichever is later.

All provisions in the contract and any attachments thereto in conflict with this amendment shall be and are hereby changed to conform with this amendment.

All provisions not in conflict with this amendment are still in effect and are to be performed at the level specified in the contract.

This amendment and all its attachments are hereby made a part of the contract. IN WITNESS THEREOF, the parties hereto have caused this ninety-two (92) page amendment to be executed by their officials thereunto duly authorized.

PROVIDER: BROWARD BEHAVIORAL HEALTH COALITION, INC.

SIGNED BY: Nan Rich

NAME: Nan Rich

TITLE: Chairperson of the Board

DATE: 8-15-2019

DEPARTMENT: FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES

SIGNED BY:

NAME: Chad Poppell

TITLE: Secretary

DATE: 9/6/19

Federal ID Number: 453675836

Contract No.	**JH343**	**Client Services** ☒	**Non-Client** ☐
CFDA No(s).	**93.958**	**Subrecipient** ☒	**Vendor** ☐
CSFA No(s).	**60114**	**Federal Funds** ☒	**State Funds** ☒

THIS CONTRACT is entered into between the Florida Department of Children and Families, hereinafter referred to as the "Department" and **Broward Behavioral Health Coalition, Inc.**, hereinafter referred to as the "Provider". If this document is denoted above as a GRANT AGREEMENT, the term "Contract" as it may appear hereinafter shall be construed to mean "Grant" or "Grant Agreement" as the context may provide. Similarly, the term "Provider" shall be construed to mean "Grantee" and the term "Contract Manager" shall be construed to mean "Grant Manager".

The section headings contained in this contract are for reference purposes only and shall not affect the meaning or interpretation of this contract.

The Department and Provider agree as follows:

1. ENGAGEMENT, TERM AND CONTRACT DOCUMENT

1.1 Purpose and Contract Amount

The Department is engaging the Provider for the purpose of **serving as a Regional Managing Entity, pursuant to s. 394.9082, F.S., to manage the day-to-day operational delivery of behavioral health services through an organized system of care, pursuant to state and federal law, within the annual appropriation**, as further described in Section 2, payable as provided in Section 3, in an amount not to exceed **$646,375,950.07.**

1.2 Official Payee and Party Representatives

1.2.1 The name, address, telephone number and e-mail address of the Provider's official payee to whom the payment shall be directed on behalf of the Provider are:

Name: **Broward Behavioral Health Coalition, Inc.**
Address: **3521 W. Broward Blvd., Suite 206**
City: **Lauderhill** State:**FL** Zip Code:**33312**
Phone: **(954) 622-8121** Ext: ____ E-mail: **squintana@bbhcflorida.org**

1.2.2 The name, address, telephone number and e-mail of the Provider's contact person responsible for the Provider's financial and administrative records:

Name: **Silvia Quintana**
Address: **3521 W. Broward Blvd., Suite 206**
City: **Lauderhill** State:**FL** Zip Code:**33312**
Phone: **(954) 622-8121** Ext: ____ E-mail: **squintana@bbhcflorida.org**

1.2.3 The name, address, telephone number and e-mail of the Provider's representative responsible for administration of the program under this Contract (and primary point of contact) are:

Name: **Silvia Quintana**
Address: **3521 W. Broward Blvd., Suite 206**
City: **Lauderhill** State:**FL** Zip Code:**33312**
Phone: **(954) 622-8121** Ext: ____ E-mail: **squintana@bbhcflorida.org**

1.2.4 The name, address, telephone number and e-mail address of the Contract Manager for the Department for this Contract are:

Name: **Frank Jowdy**
Address: **201 W. Broward Blvd., Room 512**
City: **Ft Lauderdale** State:**FL** Zip Code:**33301**
Phone: **(954) 453-3449** Ext: ____ E-mail: **Frank.Jowdy@myflfamilies.com**

Per section 402.7305(1)(a), Florida Statutes (F.S.), the Department's Contract Manager is the primary point of contact through which all contracting information flows between the Department and the Provider. Upon change of representatives (names, addresses, telephone numbers or e-mail addresses) by either party, notice shall be provided in writing to the other party.

1.3 Effective and Ending Dates

This Contract shall be effective **November 01, 2012** or the last party signature date, whichever is later. The service performance period under this Contract shall commence on **November 01, 2012** or the effective date of this Contract, whichever is later, and shall end at midnight, **Eastern** time, on **June 30, 3024**, subject to the survival of terms provisions of Section 7.4. This contract may be renewed in accordance with SS. 287.057(13) or 287.058(1)(g), F.S.

1.4 Contract Document

This Contract is composed of the documents referenced in this section.

1.4.1 The definitions found in the Standard Contract Definitions, located at: http://www.dcf.state.fl.us/admin/contracts/docs/GlossaryofContractTerms.pdf are incorporated into and made a part of this Contract. Additional definitions may be set forth in Exhibit A, Special Provisions.

1.4.2 The PUR 1000 Form (10/06 version) is hereby incorporated into and made a part of this Contract.

1.4.3 The terms of Exhibit A, Special Provisions, supplement or modify the terms of Sections 1 through 9, as provided therein.

1.4.4 In the event of a conflict between the provisions of the documents, the documents shall be interpreted in the following order of precedence:

1.4.4.1 Exhibits A through F2;

1.4.4.2 Any documents incorporated into any exhibit by reference, or included as a subset thereof;

1.4.4.3 This Standard Contract;

1.4.4.4 Any documents incorporated into this Contract by reference;

1.4.4.5 Attachments 1 through 3.

2. STATEMENT OF WORK .

The Provider shall perform all tasks and provide units of deliverables, including reports, findings, and drafts, as specified in this Contract. Unless otherwise provided in the procurement document, if any, or governing law, the Department reserves the right to increase or decrease the volume of services and to add tasks that are incidental or complimentary to the original scope of services. When such increase or decrease occurs, except where the method of payment is prescribed by law, compensation under Section 3 will be equitably adjusted by the Department to the extent that it prescribes a fixed price payment method or does not provide a method of payment for added tasks.

2.1 Scope of Work

The Scope of Work is described in Exhibit B.

2.2 Task List

The Provider shall perform all tasks set forth in the Task List, found in Exhibit C, in the manner set forth therein.

2.3 Deliverables

The Deliverables are described in Exhibit D.

2.4 Performance Measures

2.4.1 The performance measures for acceptance of deliverables are set forth in Exhibit D, Section D-3.

2.4.2 To avoid contract termination, Provider's performance must meet the minimum acceptable level of performance set forth in Exhibit E, Minimum Performance Measures, Section E-1, regardless of any other performance measures in this Contract. By execution of this Contract, the Provider hereby acknowledges and agrees that its performance under the Contract must meet these Minimum Performance Measures and that it will be bound by the conditions set forth therein. If the Provider fails to meet these measures, the Department, at its exclusive option, may allow a reasonable period, not to exceed six (6) months, for the Provider to correct performance deficiencies. If performance deficiencies are not resolved to the satisfaction of the Department within the prescribed time, and if no extenuating circumstances can be documented by the Provider to the Department's satisfaction, the Department must terminate the Contract. The Department has the sole authority to determine whether there are extenuating or mitigating circumstances. The Provider further acknowledges and agrees that during any period in which the Provider fails to meet these measures, regardless of any additional time allowed to correct performance deficiencies, payment for deliverables may be delayed or denied and financial consequences may apply.

3. PAYMENT, INVOICE AND RELATED TERMS

The Department shall pay for services performed by the Provider during the service performance period of this Contract according to the terms and conditions of this Contract in an amount not to exceed that set forth in Section 1.1, subject to the availability of funds and satisfactory performance of all terms by the Provider. Except for advances, if any, provided for in this Contract, payment shall be made only upon written acceptance of all services by the Department per Section 3.1 and shall remain subject to subsequent audit or review to confirm contract compliance. The State of Florida's performance and obligation to pay under this Contract is contingent upon an

annual appropriation by the Legislature. Any costs or services paid for under any other contract or from any other source are not eligible for payment under this Contract.

3.1 Prompt Payment and Vendor Ombudsman

Per section 215.422, F.S., the Department has five (5) working days to inspect and approve goods and services, unless the bid specifications, purchase order, or this Contract elsewhere specifies otherwise. Department determination of acceptable services shall be conclusive. Department receipt of reports and other submissions by the Provider does not constitute acceptance thereof, which occurs only through a separate and express act of the Contract Manager. For any amount that is authorized for payment but is not available within forty (40) days, measured from the latter of the date a properly completed invoice is received by the Department or the goods or services are received, inspected, and approved (or within thirty-five (35) days after the date eligibility for payment of a health care provider is determined), a separate interest penalty as described in section 215.422, F.S., will be due and payable in addition to the amount authorized for payment. Interest penalties less than one dollar will not be paid unless the Provider requests payment. A Vendor Ombudsman has been established within the Department of Financial Services and may be contacted at (850) 413-5516.

3.2 Method of Payment

The Provider shall be paid in accordance with Exhibit F.

3.3 Invoices

3.3.1 The Provider shall submit bills for fees or other compensation for services or expenses in sufficient detail for proper pre-audit and post-audit. Where itemized payment for travel expenses is permitted in this Contract, the Provider shall submit bills for any travel expenses in accordance with section 112.061, F.S., or at such lower rates as may be provided in this Contract.

3.3.2 The final invoice for payment shall be submitted to the Department no more than **45** days after the Contract ends or is terminated. If the Provider fails to do so, all rights to payment are forfeited and the Department will not honor any requests submitted after the aforesaid time period. Any payment due under the terms of this Contract may be withheld until performance of services and all reports due from the Provider and necessary adjustments thereto, have been approved by the Department.

3.4 Financial Consequences

If the Provider fails to perform in accordance with this Contract or perform the minimum level of service required by this Contract, the Department will apply financial consequences as provided for in Section 6.1. The parties agree that the penalties provided for under Section 6.1 constitute financial consequences under sections 287.058(1)(h) and 215.971(1)(c), F.S. The foregoing does not limit additional financial consequences, which may include but are not limited to refusing payment, withholding payments until deficiency is cured, tendering only partial payments, applying payment adjustments for additional financial consequences or for liquidated damages to the extent that this Contract so provides, or termination of this Contract per Section 6.2 and requisition of services from an alternate source. Any payment made in reliance on the Provider's evidence of performance, which evidence is subsequently determined to be erroneous, will be immediately due as an overpayment in accordance with Section 3.5, to the extent of such error. Financial consequences directly related to the deliverables under this Contract are defined in Exhibit F.

3.5 Overpayments and Offsets

The Provider shall return to the Department any overpayments due to unearned funds or funds disallowed that were disbursed to the Provider by the Department and any interest attributable to such funds. Should repayment not be made promptly upon discovery by the Provider or its auditor or upon written notice by the Department, the Provider will be charged interest at the lawful rate of interest on the outstanding balance until returned. Payments made for services subsequently determined by the Department to not be in full compliance with contract requirements shall be deemed overpayments. The Department shall have the right at any time to offset or deduct from any payment due under this or any other contract or agreement any amount due to the Department from the Provider under this or any other contract or agreement. If this contract involves federal or state financial assistance, the following applies: The Grantee shall return to the Department any unused funds; any accrued interest earned; and any unmatched grant funds, as detailed in the Final Financial Report, no later than 60 days following the ending date of this Contract.

3.6 MyFloridaMarketPlace Transaction Fee.

This Contract is **exempt from** the MyFloridaMarketPlace transaction fee.

4. GENERAL TERMS AND CONDITIONS GOVERNING PERFORMANCE

4.1 Compliance with Statutes, Rules and Regulations

In performing its obligations under this Contract, the Provider shall without exception be aware of and comply with all State and Federal laws, rules, Children and Families Operating Procedures (CFOPs), and regulations relating to its performance under this Contract as they may be enacted or amended from time-to-time, as well as any court or administrative order, judgment, settlement or compliance agreement involving the Department which by its nature affects the services provided under this Contract.

4.2 State Policies

The Provider shall comply with the polices set forth in the Department of Financial Services' Reference Guide for State Expenditures and active Comptroller/Chief Financial Officer Memoranda issued by the Division of Accounting and Auditing.

4.3 Independent Contractor, Subcontracting and Assignments

4.3.1 In performing its obligations under this Contract, the Provider shall at all times be acting in the capacity of an independent contractor and not as an officer, employee, or agent of the State of Florida, except where the Provider is a State agency. Neither the Provider nor any of its agents, employees, subcontractors or assignees shall represent to others that it is an agent of or has the authority to bind the Department by virtue of this Contract, unless specifically authorized in writing to do so. This Contract does not create any right in any individual to State retirement, leave benefits or any other benefits of State employees as a result of performing the duties or obligations of this Contract.

4.3.2 The Department will not furnish services of support (e.g., office space, office supplies, telephone service, secretarial or clerical support) to the Provider, or its subcontractor or assignee, unless specifically agreed to by the Department in this Contract. All deductions for social security, withholding taxes, income taxes, contributions to unemployment compensation funds and all necessary insurance for the Provider, the Provider's officers, employees, agents, subcontractors, or assignees shall be the sole responsibility of the Provider and its subcontractors. The parties agree that no joint employment is intended and that, regardless of any provision directing the manner of provision of services, the Provider and its subcontractors alone shall be responsible for the supervision, control, hiring and firing, rates of pay and terms and conditions of employment of their own employees.

4.3.3 The Provider may subcontract under this Contract

4.3.3.1 The Provider shall not subcontract for any of the work contemplated under this Contract without prior written approval of the Department, which shall not be unreasonably withheld. The Provider shall take such actions as may be necessary to ensure that it and each subcontractor of the Provider will be deemed to be an independent contractor and will not be considered or permitted to be an officer, employee, or agent of the State of Florida.

4.3.3.2 The Provider is responsible for all work performed and for all commodities produced pursuant to this Contract whether actually furnished by the Provider or by its subcontractors. Any subcontracts shall be evidenced by a written document. The Provider further agrees that the Department shall not be liable to the subcontractor in any way or for any reason relating to this Contract.

4.3.3.3 The Provider shall include, in all subcontracts (at any tier) the substance of all clauses contained in this Contract that mention or describe subcontract compliance, as well as all clauses applicable to that portion of the Provider's performance being performed by or through the subcontract.

4.3.4 To the extent that a subcontract provides for payment after Provider's receipt of payment from the Department, the Provider shall make payments to any subcontractor within seven (7) working days after receipt of full or partial payments from the Department in accordance with section 287.0585, F.S., unless otherwise stated in the contract between the Provider and subcontractor. Failure to pay within seven (7) working days will result in a penalty that shall be charged against the Provider and paid by the Provider to the subcontractor in the amount of one-half of one percent (0.5%) of the amount due per day from the expiration of the period allowed for payment. Such penalty shall be in addition to actual payments owed and shall not exceed fifteen (15%) percent of the outstanding balance due.

4.4 Provider Indemnity

Section 19 of PUR 1000 Form shall apply per its terms, except that the phrase "arising from or relating to personal injury and damage to real or personal tangible property" in the first paragraph is replaced with "arising out of or by reason of the execution of this Contract or arising from or relating to any alleged act or omission by the Provider, its agents, employees, partners, or subcontractors in relation to this agreement," and the following additional terms will also apply:

4.4.1 If the Provider removes an infringing product because it is not reasonably able to modify that product or secure the Department the right to continue to use that product, the Provider shall immediately replace that product with a non-infringing product that the Department determines to be of equal or better functionality or be liable for the Department's cost in so doing.

4.4.2 Further, the Provider shall indemnify the Department for all costs and attorneys' fees arising from or relating to Provider's claim that a record contains trade secret information that is exempt from disclosure; or arising from or relating to the scope of the Provider's redaction of the record, as provided for under Section 5.3, including litigation initiated by the Department.

4.4.3 The Provider's inability to evaluate liability or its evaluation of liability shall not excuse its duty to defend and indemnify after receipt of notice. Only an adjudication or judgment after the highest appeal is exhausted finding the Department negligent shall excuse the Provider of performance under this provision, in which case the Department shall have no obligation to reimburse the Provider for the cost of its defense. If the Provider is an agency or subdivision of the State, its obligation to indemnify, defend and hold harmless the Department shall be to the extent permitted by section 768.28, F.S. or other applicable law, and without waiving the limits of sovereign immunity.

4.5 Insurance

The Provider shall maintain continuous adequate liability insurance coverage during the existence of this Contract and any renewal(s) and extension(s) thereof. With the exception of a State agency or subdivision as defined by subsection 768.28(2), F.S., by execution of this Contract, the Provider accepts full responsibility for identifying and determining the type(s) and extent of liability insurance necessary to provide reasonable financial protections for the Provider and the clients to be served under this Contract. Upon the execution of this Contract, the Provider shall furnish the Department written verification supporting both the determination and existence of such insurance coverage and shall furnish verification of renewal or replacement thereof prior to the expiration or cancellation. The Department reserves the right to require additional insurance as specified in this Contract.

4.6 Notice of Legal Actions

The Provider shall notify the Department of potential or actual legal actions taken against the Provider related to services provided through this Contract or that may impact the Provider's ability to deliver the contractual services, or that may adversely impact the Department. The Provider shall notify the Department's Contract Manager within ten (10) days of Provider becoming aware of such actions or potential actions or from the day of the legal filing, whichever comes first.

4.7 Intellectual Property

All intellectual property, inventions, written or electronically created materials, including manuals, presentations, films, or other copyrightable materials, arising in relation to Provider's performance under this Contract, and the performance of all of its officers, agents and subcontractors in relation to this Contract, are works for hire for the benefit of the Department, fully compensated for by the Contract amount. Neither the Provider nor any of its officers, agents nor subcontractors may claim any interest in any intellectual property rights accruing under or in connection with the performance of this Contract. It is specifically agreed that the Department shall have exclusive rights to all data processing software falling within the terms of section 119.084, F.S., which arises or is developed in the course of or as a result of work or services performed under this Contract, or in any way connected herewith. Notwithstanding the foregoing provision, if the Provider is a university and a member of the State University System of Florida, then section 1004.23, F.S., shall apply.

4.7.1 If the Provider uses or delivers to the Department for its use or the use of its employees, agents or contractors, any design, device, or materials covered by letters, patent, or copyright, it is mutually agreed and understood that, except as to those items specifically listed in Exhibit A as having specific limitations, the compensation paid pursuant to this Contract includes all royalties or costs arising from the use of such design, device, or materials in any way involved in the work contemplated by this Contract. For purposes of this provision, the term "use" shall include use by the Provider during the term of this Contract and use by the Department its employees, agents or contractors during the term of this Contract and perpetually thereafter.

4.7.2 All applicable subcontracts shall include a provision that the Federal awarding agency reserves all patent rights with respect to any discovery or invention that arises or is developed in the course of or under the subcontract. Notwithstanding the foregoing provision, if the Provider or one of its subcontractors is a university and a member of the State University System of Florida, then section 1004.23, F.S., shall apply, but the Department shall retain a perpetual, fully-paid, nonexclusive license for its use and the use of its contractors of any resulting patented, copyrighted or trademarked work products.

4.8 Transition Activities

Continuity of service is critical when service under this Contract ends and service commences under a new contract. Accordingly, when service will continue through another provider upon the expiration or earlier termination of this Contract, the Provider shall, without additional compensation, complete all actions necessary to smoothly transition service to the new provider. This includes but is not limited to the transfer of relevant data and files, as well as property funded or provided pursuant to this Contract. The Provider shall be required to support an orderly transition to the next provider no later than the expiration or earlier termination of this Contract and shall support the requirements for transition as specified in a Department-approved Transition Plan, which shall be developed jointly with the new provider in consultation with the Department.

4.9 Real Property

Any State funds provided for the purchase of or improvements to real property are contingent upon the Provider granting to the State a security interest in the property at least to the amount of the State funds provided for at least five (5) years from the date of purchase or the completion of the improvements or as further required by law. As a condition of receipt of State funding for this purpose, if the Provider disposes of the property before the Department's interest is vacated, the Provider will refund the proportionate share of the State's initial investment, as adjusted by depreciation.

4.10 Publicity

Without limitation, the Provider and its employees, agents, and representatives will not, without prior Departmental written consent in each instance, use in advertising, publicity or any other promotional endeavor any State mark, the name of the State's mark, the name of the State or any State agency or affiliate or any officer or employee of the State, or any State program or service, or represent, directly or indirectly, that any product or service provided by the Provider has been approved or endorsed by the State, or refer to the existence of this Contract in press releases, advertising or materials distributed to the Provider's prospective customers.

4.11 Sponsorship

As required by section 286.25, F.S., if the Provider is a non-governmental organization which sponsors a program financed wholly or in part by State funds, including any funds obtained through this Contract, it shall, in publicizing, advertising, or describing the sponsorship of the program state: "Sponsored by (Provider's name) and the State of Florida, Department of Children and Families". If the sponsorship reference is in written material, the words "State of Florida, Department of Children and Families" shall appear in at least the same size letters or type as the name of the organization.

4.12 Employee Gifts

The Provider agrees that it will not offer to give or give any gift to any Department employee during the service performance period of this Contract and for a period of two years thereafter. In addition to any other remedies available to the Department, any violation of this provision will result in referral of the Provider's name and description of the violation of this term to the Department of Management Services for the potential inclusion of the Provider's name on the suspended vendors list for an appropriate period. The Provider will ensure that its subcontractors, if any, comply with these provisions.

4.13 Mandatory Reporting Requirements

The Provider and any subcontractor must comply with and inform its employees of the following mandatory reporting requirements. Each employee of the Provider, and of any subcontractor, providing services in connection with this Contract who has any knowledge of a reportable incident shall report such incident as follows:

4.13.1 A reportable incident is defined in CFOP 180-4, which can be obtained from the Contract Manager.

4.13.2 Reportable incidents that may involve an immediate or impending impact on the health or safety of a client shall be immediately reported to the Contract Manager.

4.13.3 Other reportable incidents shall be reported to the Department's Office of Inspector General through the Internet at http://www.dcf.state.fl.us/admin/ig/rptfraud1.shtml or by completing a Notification/Investigation Request (Form CF 1934) and emailing the request to the Office of Inspector General at IG.Complaints@myflfamilies.com. The Provider and subcontractor may also mail the completed form to the Office of Inspector General, 1317 Winewood Boulevard, Building 5, 2nd Floor, Tallahassee, Florida, 32399-0700; or via fax at (850) 488-1428.

4.14 Employment Screening

4.14.1 The Provider shall ensure that all staff utilized by the Provider and its subcontractors (hereinafter, "Contracted Staff") that are required by Florida law and by CFOP 60-25, Chapter 2, which is hereby incorporated by reference to be screened in accordance with chapter 435, F.S., are of good moral character and meet the Level 2 Employment Screening standards specified by sections 435.04, 110.1127, and subsection 39.001(2), F.S., as a condition of initial and continued employment that shall include but not be limited to:

4.14.1.1 Employment history checks;

4.14.1.2 Fingerprinting for all criminal record checks;

4.14.1.3 Statewide criminal and juvenile delinquency records checks through the Florida Department of Law Enforcement (FDLE);

4.14.1.4 Federal criminal records checks from the Federal Bureau of Investigation via the Florida Department of Law Enforcement; and

4.14.1.5 Security background investigation, which may include local criminal record checks through local law enforcement agencies.

4.14.1.6 Attestation by each employee, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to chapter 435 and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer.

4.14.2 The Provider shall sign the Florida Department of Children and Families Employment Screening Affidavit each State fiscal year (no two such affidavits shall be signed more than 13 months apart) for the term of the Contract stating that all required staff have been screened or the Provider is awaiting the results of screening.

4.14.3 The Department requires, as applicable, the use of the Officer of Inspector General's Request for Reference Check form (CF 774), which states: "As part of the screening of an applicant being considered for appointment to a career service, selected exempt service, senior management, or OPS position with the Department of Children and Families or a Contract or sub-contract provider, a check with the Office of Inspector General (IG) is required to determine if the individual is or has been a subject of an investigation with the IG's Office. The request will only be made on the individual that is being recommended to be hired for the position if that individual has previously worked for the Contract or sub-contract provider, or if that individual is being promoted, transferred or demoted within the Contract or sub-contract provider."

4.15 Human Subject Research

The Provider shall comply with the requirements of CFOP 215-8 for any activity under this Contract involving human subject research within the scope of 45 Code of Federal Regulations (CFR), Part 46, and 42 United States Code (U.S.C.) §§ 289, et seq., and may not commence such activity until review and approval by the Department's Human Protections Review Committee and a duly constituted Institutional Review Board.

4.16 Coordination of Contracted Services

Section 287.0575, F.S., mandates various duties and responsibilities for certain State agencies and their contracted service providers, and requires the following Florida health and human services agencies to coordinate their monitoring of contracted services: Department of Children and Families, Agency for Persons with Disabilities, Department of Health, Department of Elderly Affairs, and Department of Veterans Affairs, where applicable.

In accordance with section 287.0575(2), F.S., each contract service provider that has more than one contract with one or more of the five Florida health and human services agencies must provide a comprehensive list of their health and human services contracts to their respective Contract Manager(s). The list must include the following information:

4.16.1 Name of each contracting State agency and the applicable office or program issuing the contract.

4.16.2 Name of each contracting State agency and the applicable office or program issuing the contract.

4.16.3 Identifying name and number of the contract.

4.16.4 Starting and ending date of each contract.

4.16.5 Amount of each contract.

4.16.6 A brief description of the purpose of the contract and the types of services provided under each contract.

4.16.7 Name and contact information of each Contract Manager.

5. RECORDS, AUDITS AND DATA SECURITY

5.1 Records, Retention, Audits, Inspections and Investigations

5.1.1 The Provider shall establish and maintain books, records and documents (including electronic storage media) sufficient to reflect all income and expenditures of funds provided by the Department under this Contract. Upon demand, at no additional cost to the Department, the Provider will facilitate the duplication and transfer of any records or documents during the term of this Contract and the required retention period in Section 5.1.2. These records shall be made available at all reasonable times for inspection, review, copying, or audit by Federal, State, or other personnel duly authorized by the Department.

5.1.2 Retention of all client records, financial records, supporting documents, statistical records, and any other documents (including electronic storage media) pertinent to this Contract shall be maintained by the Provider during the term of this Contract and retained for a period of six (6) years after completion of the Contract or longer when required by law. In the event an audit is required under this Contract, records shall be retained for a minimum period of six (6) years after the audit report is issued or until resolution of any audit findings or litigation based on the terms of this Contract, at no additional cost to the Department.

5.1.3 At all reasonable times for as long as records are maintained, persons duly authorized by the Department and Federal auditors, pursuant to 2 CFR § 200.336, shall be allowed full access to and the right to examine any of the Provider's contracts and related records and documents, regardless of the form in which kept.

5.1.4 A financial and compliance audit shall be provided to the Department as specified in this Contract and in Attachment 1.

5.1.5 The Provider shall comply and cooperate immediately with any inspections, reviews, investigations, or audits deemed necessary by The Office of the Inspector General (section 20.055, F.S.).

5.1.6 No record may be withheld nor may the Provider attempt to limit the scope of any of the foregoing inspections, reviews, copying, transfers or audits based on any claim that any record is exempt from public inspection or is confidential, proprietary or trade secret in nature; provided, however, that this provision does not limit any exemption to public inspection or copying to any such record.

5.2 Inspections and Corrective Action

The Provider shall permit all persons who are duly authorized by the Department to inspect and copy any records, papers, documents, facilities, goods and services of the Provider which are relevant to this Contract, and to interview any clients, employees and subcontractor employees of the Provider to assure the Department of the satisfactory performance of the terms and conditions of this Contract. Following such review, the Department may direct the development, by the Provider, of a corrective action plan where appropriate. The Provider hereby agrees to timely correct all deficiencies identified in the Department's direction. This provision will not limit the Department's choice of remedies under law, rule, or this contract.

5.3 Provider's Confidential and Exempt Information

5.3.1 By executing this Contract, the Provider acknowledges that, having been provided an opportunity to review all provisions hereof, all provisions of this Contract not specifically identified in writing by the Provider prior to execution hereof as "confidential" or "exempt" will be posted by the Department on the public website maintained by the Department of Financial Services pursuant to section 215.985, F.S. The Provider, upon written request of the Department, shall promptly provide a written statement of the basis for the exemption applicable to each provision identified by the Provider as "confidential" or "exempt", including the statutory citation to an exemption created or afforded by statute, and state with particularity the reasons for the conclusion that the provision is exempt or confidential.

5.3.2 Any claim by Provider of trade secret (proprietary) confidentiality for any information contained in Provider's documents (reports, deliverables or workpapers, etc., in paper or electronic form) submitted to the Department in connection with this Contract will be waived, unless the claimed confidential information is submitted in accordance with the following standards:

5.3.2.1 The Provider must clearly label any portion of the documents, data, or records submitted that it considers exempt from public inspection or disclosure pursuant to Florida's Public Records Law as trade secret. The labeling will include a justification citing specific statutes and facts that authorize exemption of the information from public disclosure. If different exemptions are claimed to be applicable to different portions of the protected information, the Provider shall include information correlating the nature of the claims to the particular protected information.

5.3.2.2 The Department, when required to comply with a public records request including documents submitted by the Provider, may require the Provider to expeditiously submit redacted copies of documents marked as trade secret in accordance with Section 5.3.2.1. Accompanying the submission shall be an updated version of the justification under Section 5.3.2.1, correlated specifically to redacted information, either confirming that the statutory and factual basis originally asserted remain unchanged or indicating any changes affecting the basis for the asserted exemption from public inspection or disclosure. The redacted copy must exclude or obliterate only those exact portions that are claimed to be trade secret. If the Provider fails to promptly submit a redacted copy, the Department is authorized to produce the records sought without any redaction of proprietary or trade secret information.

5.3.3 The Provider shall be responsible for defending its claim that each and every portion of the redactions of trade secret information are exempt from inspection and copying under Florida's Public Records Law.

5.4 Health Insurance Portability and Accountability Act

☐ The Provider certifies that neither it nor its subcontractors will have access to, receive or provide Protected Health Information within the meaning of the Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d.) and the regulations promulgated thereunder (45 CFR Parts 160, 162, and 164) incidental to performance of this Contract.

☒ In compliance with 45 CFR § 164.504(e), the Provider shall comply with the provisions of Attachment 2 to this Contract, governing the safeguarding, use and disclosure of Protected Health Information created, received, maintained, or transmitted by the Provider or its subcontractors incidental to the Provider's performance of this Contract.

5.5 Information Security

The Provider shall comply with, and be responsible for ensuring subcontractor compliance as if they were the Provider with, the following information security requirements whenever the Provider or its subcontractors have access to Department information systems or maintain any client or other confidential information in electronic form:

5.5.1 An appropriately skilled individual shall be identified by the Provider to function as its Information Security Officer. The Information Security Officer shall act as the liaison to the Department's security staff and will maintain an appropriate level of information security for Department information systems or any client or other confidential information the Provider is collecting or using in the performance of this Contract. An appropriate level of security includes approving and tracking all who request or have access, through the Provider's access, to Department information systems or any client or other confidential information. The Information Security Officer will ensure that any access to Department information systems or any client or other confidential information is removed immediately upon such access no longer being required for Provider's performance under this contract.

5.5.2 The Provider shall provide the latest Departmental security awareness training to all who request or have access, through the Provider's access, to Department information systems or any client or other confidential information.

5.5.3 All who request or have access, through the Provider's access, to Department information systems or any client or other confidential information shall comply with, and be provided a copy of CFOP 50-2, and shall sign the DCF Security Agreement form CF 0114 annually. A copy of CF 0114 may be obtained from the Contract Manager.

5.5.4 The Provider shall prevent unauthorized disclosure or access, from or to Department information systems or client or other confidential information. Client or other confidential information on systems and network capable devices shall be encrypted per CFOP 50-2.

5.5.5 The Provider agrees to notify the Contract Manager as soon as possible, but no later than five (5) business days following the determination of any potential or actual unauthorized disclosure or access to Department information systems or to any client or other confidential information.

5.5.6 The Provider shall, at its own cost, comply with section 501.171, F.S. The Provider shall also. at its own cost. Implement measures deemed appropriate by the Department to avoid or mitigate potential injury to any person due to potential or actual unauthorized disclosure or access to Department information systems or to any client or other confidential information.

5.6 Public Records

5.6.1 The Provider shall allow public access to all documents, papers, letters, or other public records as defined in subsection 119.011(12), F.S. as prescribed by subsection 119.07(1) F.S., made or received by the Provider in conjunction with this Contract except that public records which are made confidential by law must be protected from disclosure. As required by section

287.058(1)(c), F.S., it is expressly understood that the Provider's failure to comply with this provision shall constitute an immediate breach of contract for which the Department may unilaterally terminate this Contract.

5.6.2 As required by section 119.0701, F.S., to the extent that the Provider is acting on behalf of the Department within the meaning of section 119.011(2), F.S., the Provider shall:

5.6.2.1 Keep and maintain public records that ordinarily and necessarily would be required by the Department in order to perform the service.

5.6.2.2 Upon request from the Department's custodian of public records, provide to the Department a copy of requested records or allow the records to be inspected or copied within a reasonable time at a cost that does not exceed the cost provided in Chapter 119, F.S., or as otherwise provided by law.

5.6.2.3 Ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law for the duration of the contract term and following completion of the contract if the Provider does not transfer the records to the Department.

5.6.2.4 Upon completion of the contract, transfer, at no cost, to the Department all public records in possession of the Provider or keep and maintain public records required by the Department to perform the service. If the Provider transfers all public records to the Department upon completion of the contract, the Provider shall destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. If the Provider keeps and maintains public records upon completion of the contract, the Provider shall meet all applicable requirements for retaining public records. All records stored electronically must be provided to the Department, upon request from the Department's custodian of public records, in a format that is compatible with the information technology systems of the Department.

5.6.3 IF THE PROVIDER HAS QUESTIONS REGARDING THE APPLICATION OF CHAPTER 119, F.S., TO THE PROVIDER'S DUTY TO PROVIDE PUBLIC RECORDS RELATING TO THIS CONTRACT, CONTACT THE CUSTODIAN OF PUBLIC RECORDS AT 850-487-1111, OR BY EMAIL AT DCFCustodian@MYFLFAMILIES.COM, OR BY MAIL AT: DEPARTMENT OF CHILDREN AND FAMILIES, 1317 WINEWOOD BLVD., TALLAHASSEE, FL 32399.

6. PENALTIES, TERMINATION AND DISPUTE RESOLUTION

6.1 Financial Penalties for Failure to Take Corrective Action

6.1.1 In accordance with the provisions of section 402.73(1), F.S., and Rule 65-29.001, F.A.C., should the Department require a corrective action to address noncompliance under this Contract, incremental penalties listed in section 6.1.2 through section 6.1.3 shall be imposed for Provider failure to achieve the corrective action. These penalties are cumulative and may be assessed upon each separate failure to comply with instructions from the Department to complete corrective action, but shall not exceed ten (10%) of the total contract payments during the period in which the corrective action plan has not been implemented or in which acceptable progress toward implementation has not been made. These penalties do not limit or restrict the Department's application of any other remedy available to it under law or this Contract.

6.1.2 The increments of penalty imposition that shall apply, unless the Department determines that extenuating circumstances exist, shall be based upon the severity of the noncompliance, nonperformance, or unacceptable performance that generated the need for corrective action plan, in accordance with the following standards.

6.1.2.1 Noncompliance that is determined by the Department to have a direct effect on client health and safety shall result in the imposition of a ten percent (10%) penalty of the total contract payments during the period in which the corrective action plan has not been implemented or in which acceptable progress toward implementation has not been made.

6.1.2.2 Noncompliance involving the provision of service not having a direct effect on client health and safety shall result in the imposition of a five percent (5%) penalty.

6.1.2.3 Noncompliance as a result of unacceptable performance of administrative tasks shall result in the imposition of a two percent (2%) penalty.

6.1.3 The deadline for payment shall be as stated in the Order imposing the financial penalties. In the event of nonpayment the Department may deduct the amount of the penalty from invoices submitted by the Provider.

6.2 Termination

6.2.1 In accordance with Section 22 of PUR 1000 Form, this Contract may be terminated by the Department without cause upon no less than thirty (30) calendar days' notice in writing to the Provider unless a sooner time is mutually agreed upon in writing.

6.2.2 This Contract may be terminated by the Provider upon no less than one-hundred and twenty (120) calendar days' notice in writing to the Department unless another notice period is mutually agreed upon in writing.

6.2.3 In the event funds for payment pursuant to this Contract become unavailable, the Department may terminate this Contract upon no less than twenty-four (24) hours' notice in writing to the Provider. The Department shall be the final authority as to the availability and adequacy of funds.

6.2.4 In the event the Provider fails to fully comply with the terms and conditions of this Contract, the Department may terminate the Contract upon no less than twenty-four (24) hours' notice in writing to the Provider, excluding Saturday, Sunday, and Holidays. Such notice may be issued without providing an opportunity for cure if it specifies the nature of the noncompliance and states that provision for cure would adversely affect the interests of the State or is not permitted by law or regulation. Otherwise, notice of termination will be issued after the Provider's failure to fully cure such noncompliance within the time specified in a written notice of noncompliance issued by the Department specifying the nature of the noncompliance and the actions required to cure such noncompliance. In addition, the Department may employ the default provisions in Rule 60A-1.006(3), F.A.C., but is not required to do so in order to terminate the Contract. The Department's failure to demand performance of any provision of this Contract shall not be deemed a waiver of such performance. The Department's waiver of any one breach of any provision of this Contract shall not be deemed to be a waiver of any other breach and neither event shall be construed to be a modification of the terms and conditions of this Contract. The provisions herein do not limit the Department's right to remedies at law or in equity.

6.2.5 Failure to have performed any contractual obligations under any other contract with the Department in a manner satisfactory to the Department will be a sufficient cause for termination. Termination shall be upon no less than twenty-four (24) hours' notice in writing to the Provider. To be terminated under this provision, the Provider must have:

6.2.5.1 Previously failed to satisfactorily perform in a contract with the Department, been notified by the Department of the unsatisfactory performance, and failed to timely correct the unsatisfactory performance to the satisfaction of the Department; or

6.2.5.2 Had a contract terminated by the Department for cause.

6.2.6 In the event of termination under Sections 6.2.1 or 6.2.3, the Provider will be compensated for any work satisfactorily completed through the date of termination or an earlier date of suspension of work per Section 21 of the PUR 1000.

6.2.7 If this Contract is for an amount of $1 Million or more, the Department may terminate this Contract at any time the Provider is found to have submitted a false certification under section 287.135, F.S., or been placed on the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List. Regardless of the amount of this contract, the Department may terminate this contract at any time the Provider is found to have been placed on the Scrutinized Companies that Boycott Israel List or is engaged in a boycott of Israel.

6.3 Dispute Resolution

6.3.1 Any dispute concerning performance of this Contract or payment hereunder shall be decided by the Department, which shall be reduced to writing and a copy of the decision shall be provided to the Provider by the Contract Manager. The decision shall be final and conclusive unless within twenty-one (21) calendar days from the date of receipt of the Department's decision, the Provider delivers to the Contract Manager a petition for alternative dispute resolution.

6.3.2 After receipt of a petition for alternative dispute resolution the Department and the Provider shall attempt to amicably resolve the dispute through negotiations. Timely delivery of a petition for alternative dispute resolution and completion of the negotiation process shall be a condition precedent to any legal action by the Provider concerning this Contract.

6.3.3 After timely delivery of a petition for alternative dispute resolution, the parties may employ any dispute resolution procedures described in the exhibits or other attachments, or mutually agree to an alternative binding or nonbinding dispute resolution process, the terms of which shall be reduced to writing and executed by both parties.

6.3.4 Completion of such agreed process shall be deemed to satisfy the requirement for completion of the negotiation process.

6.3.5 This section shall not limit the parties' rights of termination under Section 6.2.

6.3.6 All notices provided by the Department under Section 6 shall be in writing on paper, physically sent to the person identified in Section 1.2.3 via the U.S. Postal Service or any other delivery service that provides verification of delivery, or via hand delivery. All notices provide by the Provider under Section 6 shall be in writing on paper, physically sent to the person identified in Section 1.2.4 via U.S. Postal Service or any other delivery service that provides verification of delivery, or via hand delivery.

7. OTHER TERMS

7.1 Governing Law and Venue

This Contract is executed and entered into in the State of Florida, and shall be construed, performed and enforced in all respects in accordance with Florida law, without regard to Florida provisions for conflict of laws. State Courts of competent jurisdiction in Florida shall have exclusive jurisdiction in any action regarding this Contract and venue shall be in Leon County, Florida. Unless otherwise provided in any other provision or amendment hereof, any amendment, extension or renewal (when authorized) may be executed in counterparts as provided in Section 46 of the PUR 1000 Form.

7.2 No Other Terms

There are no provisions, terms, conditions, or obligations other than those contained herein, and this Contract shall supersede all previous communications, representations, or agreements, either verbal or written between the parties.

7.3 Severability of Terms

If any term or provision of this Contract is legally determined unlawful or unenforceable, the remainder of the Contract shall remain in full force and effect and such term or provision shall be stricken.

7.4 Survival of Terms

Unless a provision hereof expressly states otherwise, all provisions hereof concerning obligations of the Provider and remedies available to the Department survive the ending date or an earlier termination of this Contract. The Provider's performance pursuant to such surviving provisions shall be without further payment.

7.5 Modifications

Modifications of provisions of this Contract shall be valid only when they have been reduced to writing and duly signed by both parties. The rate of payment and the total dollar amount may be adjusted retroactively to reflect price level increases and changes in the rate of payment when these have been established through the appropriations process and subsequently identified in the Department's operating budget.

7.6 Anticompetitive Agreements

The Provider will not offer, enter into nor enforce any formal or informal agreement with any person, firm or entity under which the parties agree to refrain from competing for any future service contract or limit in any manner the ability of either party to obtain employment by or provide services to the Department or a provider of services to the Department.

7.7 Communications

Except where otherwise provided in this Contract, communications between the parties regarding this Contract may be by any commercially reasonable means. Where this Contract calls for communication in writing, such communication includes email, and attachments thereto are deemed received when the email is received.

7.8 Accreditation

The Department is committed to ensuring provision of the highest quality services to the persons we serve. Accordingly, the Department has expectations that where accreditation is generally accepted nationwide as a clear indicator of quality service, the majority of the Department's providers will either be accredited, have a plan to meet national accreditation standards, or will initiate a plan within a reasonable period of time.

7.9 Transitioning Young Adults

The Provider understands the Department's interest in assisting young adults aging out of the dependency system. The Department encourages Provider participation with the local Community-Based Care Lead Agency Independent Living Program to offer gainful employment to youth in foster care and young adults transitioning from the foster care system.

7.10 DEO and Workforce Florida

The Provider understands that the Department, the Department of Economic Opportunity, and Workforce Florida, Inc., have jointly implemented an initiative to empower recipients in the Temporary Assistance to Needy Families Program to enter and remain in gainful employment. The Department encourages Provider participation with the Department of Economic Opportunity and Workforce Florida.

7.11 Purchases by Other Agencies

The Department of Management Services may approve this Contract as an alternate contract source pursuant to Rule 60A-1.045, Florida Administrative Code, if requested by another agency. Other State agencies may purchase from the resulting contract, provided that the Department of Management Services has determined that the contract's use is cost-effective and in the best interest of the State. Upon such approval, the Provider may, at its discretion, sell these commodities or services to additional agencies, upon the terms and conditions contained herein.

7.12 Unauthorized Aliens

Unauthorized aliens shall not be employed. Employment of unauthorized aliens shall be cause for unilateral cancellation of this Contract by the Department for violation of section 274A of the Immigration and Nationality Act (8 U.S.C. § 1324a) and section 101 of the Immigration Reform and Control Act of 1986. The Provider and its subcontractors will enroll in and use the E-verify system established by the U.S. Department of Homeland Security to verify the employment eligibility of its employees and its subcontractors' employees performing under this Contract. Employees assigned to the contract means all persons employed or assigned (including subcontractors) by the Provider or a subcontractor during the contract term to perform work pursuant to this contract within the United States and its territories.

7.13 Civil Rights Requirements

These requirements shall apply to the Provider and all contractors, subcontractors, subgrantees or others with whom it arranges to provide services or benefits to clients or employees in connection with its programs and activities.

7.13.1 The Provider shall comply with the provisions in accordance with Title VII of the Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, or the Florida Civil Rights Act of 1992, as applicable the Provider shall not discriminate against any employee (or applicant for employment) in the performance of this Contract because of race, color, religion, sex, national origin, disability, age, or marital status.

7.13.2 The Provider shall not discriminate against any applicant, client, or employee in service delivery or benefits in connection with any of its programs and activities in accordance with 45 CFR, Parts 80, 83, 84, 90, and 91, Title VI of the Civil Rights Act of 1964, or the Florida Civil Rights Act of 1992, as applicable and CFOP 60-16.

7.13.3 If employing fifteen or more employees, the Provider shall complete the Civil Rights Compliance Checklist, CF Form 946 within thirty (30) days of execution of this Contract and annually thereafter in accordance with CFOP 60-16 and 45 CFR, Part 80.

7.14 Use of Funds for Lobbying Prohibited

The Provider shall comply with the provisions of sections 11.062 and 216.347, F.S., which prohibit the expenditure of contract funds for the purpose of lobbying the Legislature, judicial branch, or a State agency.

7.15 Public Entity Crime and Discriminatory Contractors

Pursuant to sections 287.133 and 287.134, F.S., the following restrictions are placed on the ability of persons placed on the convicted vendor list or the discriminatory vendor list. When a person or affiliate has been placed on the convicted vendor list following a conviction for a public entity crime, or an entity or affiliate has been placed on the discriminatory vendor list, such person, entity or affiliate may not submit a bid, proposal, or reply on a contract to provide any goods or services to a public entity; may not submit a bid, proposal, or reply on a contract with a public entity for the construction or the repair of a public building or public work; may not submit bids, proposals, or replies on leases of real property to a public entity; may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity; and may not transact business with any public entity; provided, however, that the prohibition on persons or affiliates placed on the convicted vendor shall be limited to business in excess of the threshold amount provided in section 287.017, F.S., for CATEGORY TWO for a period of thirty-six (36) months from the date of being placed on the convicted vendor list.

7.16 Whistleblower's Act Requirements

In accordance with subsection 112.3187, F.S., the Provider and its subcontractors shall not retaliate against an employee for reporting violations of law, rule, or regulation that creates substantial and specific danger to the public's health, safety, or welfare to an appropriate agency. Furthermore, agencies or independent contractors shall not retaliate against any person who discloses information to an appropriate agency alleging improper use of governmental office, gross waste of funds, or any other abuse or gross neglect of duty on the part of an agency, public officer, or employee. The Provider and any subcontractor shall inform its employees that they and other persons may file a complaint with the Office of Chief Inspector General, Agency Inspector General, the Florida Commission on Human Relations or the Whistle-blower's Hotline number at 1-800-543-5353.

7.17 PRIDE

Articles which are the subject of or are required to carry out this Contract shall be purchased from Prison Rehabilitative Industries and Diversified Enterprises, Inc., (PRIDE) identified under Chapter 946, F.S., in the same manner and under the procedures set forth in subsections 946.515(2) and (4), F.S. For purposes of this Contract, the Provider shall be deemed to be substituted for the Department insofar as dealings with PRIDE. This clause is not applicable to subcontractors unless otherwise required by law. An abbreviated list of products/services available from PRIDE may be obtained by contacting PRIDE, (800) 643-8459.

7.18 Recycled Products

The Provider shall procure any recycled products or materials, which are the subject of or are required to carry out this Contract, in accordance with the provisions of sections 403.7065, F.S.

8. FEDERAL FUNDS APPLICABILITY

The terms in this section apply if Federal Funds are used to fund this Contract.

8.1 Federal Law

8.1.1 The Provider shall comply with the provisions of Federal law and regulations including, but not limited to, 2 CFR, Part 200, and other applicable regulations.

8.1.2 If this Contract contains $10,000 or more of Federal Funds, the Provider shall comply with Executive Order 11246, Equal Employment Opportunity, as amended by Executive Order 11375 and others, and as supplemented in Department of Labor regulation 41 CFR, Part 60 if applicable.

8.1.3 If this Contract contains over $150,000 of Federal Funds, the Provider shall comply with all applicable standards, orders, or regulations issued under section 306 of the Clean Air Act, as amended (42 U.S.C. § 7401 et seq.), section 508 of the Federal Water Pollution Control Act, as amended (33 U.S.C. § 1251 et seq.), Executive Order 11738, as amended and where applicable, and Environmental Protection Agency regulations (2 CFR, Part 1500). The Provider shall report any violations of the above to the Department.

8.1.4 No Federal Funds received in connection with this Contract may be used by the Provider, or agent acting for the Provider, or subcontractor to influence legislation or appropriations pending before the Congress or any State legislature. If this Contract contains Federal funding in excess of $100,000, the Provider must, prior to contract execution, complete the Certification Regarding Lobbying form, Attachment 3. All disclosure forms as required by the Certification Regarding Lobbying form must be completed and returned to the Contract Manager, prior to payment under this Contract.

8.1.5 If this Contract provides services to children up to age 18, the Provider shall comply with the Pro-Children Act of 1994 (20 U.S.C. § 6081). Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation or the imposition of an administrative compliance order on the responsible entity, or both.

8.1.6 If the Provider is a federal subrecipient or pass-through entity, then the Provider and its subcontractors who are federal subrecipients or pass-through entities are subject to the following: A contract award (see 2 CFR § 180.220) must not be made to parties listed on the government-wide exclusions in the System for Award Management (SAM), in accordance with the OMB guidelines in 2 CFR, Part 180 that implement Executive Orders 12549 and 12689, "Debarment and Suspension." SAM Exclusions contains the names of parties debarred, suspended, or otherwise excluded by agencies, as well as parties declared ineligible under statutory or regulatory authority other than Executive Order 12549.

8.1.7 If the Provider is a federal subrecipient or pass through entity, the Provider and its subcontractors who are federal subrecipients or pass-through entities, must determine whether or not its subcontracts are being awarded to a "contractor" or a

"subrecipient," as those terms are defined in 2 CFR, Part 200. If a Provider's subcontractor is determined to be a subrecipient, the Provider must ensure the subcontractor adheres to all the applicable requirements in 2 CFR, Part 200.

8.2 Federal Funding Accountability and Transparency Act (FFATA)

The FFATA Act of 2006 is an act of Congress that requires the full disclosure to the public of all entities or organizations receiving federal funds.

8.2.1 The Provider will complete and sign the FFATA Certification of Executive Compensation Reporting Requirements form (CF 1111 or successor) if this Contract includes $30,000 or more in Federal Funds (as determined over its entire term). The Provider shall also report the total compensation of its five most highly paid executives if it also receives in excess of 80% of its annual gross revenues from Federal Funds and receives more than $25 million in total federal funding.

8.2.2 The Digital Accountability and Transparency Act (DATA) 2014 is an expansion of the FFATA Act of 2006, the purpose is for further transparency by establishing government-wide data identifiers and standardized reporting formats to recipient and sub-recipients.

8.3 Federal Whistleblower Requirements

Pursuant to Section 11(c) of the OSH Act of 1970 and the subsequent federal laws expanding the act, the Provider is prohibited from discriminating against employees for exercising their rights under the OSH Act. Details of the OSH Act can be found at this website: http://www.whistleblowers.gov.

9. CLIENT SERVICES APPLICABILITY

The terms in this section apply if the box for Client Services is checked at the beginning of this Contract.

9.1 Client Risk Prevention

If services to clients are to be provided under this Contract, the Provider and any subcontractors shall, in accordance with the client risk prevention system, report those reportable situations listed in CFOP 215-6 in the manner prescribed in CFOP 215-6. The Provider shall immediately report any knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child, aged person, or disabled adult to the Florida Abuse Hotline on the statewide toll-free telephone number (1-800-96ABUSE). As required by Chapters 39 and 415, F.S., this provision is binding upon both the Provider and its employees.

9.2 Emergency Preparedness Plan

If the tasks to be performed pursuant to this Contract include the physical care or supervision of clients, the Provider shall, within thirty (30) days of the execution of this contract, submit to the Contract Manager an emergency preparedness plan which shall include provisions for records protection, alternative accommodations for clients in substitute care, supplies, and a recovery plan that will allow the Provider to continue functioning in compliance with the executed contract in the event of an actual emergency. For the purpose of disaster planning, the term "supervision" includes a child who is under the jurisdiction of a dependency court. Children may remain in their homes, be placed in a non-licensed relative/non-relative home, or be placed in a licensed foster care setting. No later than twelve months following the Department's original acceptance of a plan and every twelve (12) months thereafter, the Provider shall submit a written certification that it has reviewed its plan, along with any modifications to the plan, or a statement that no modifications were found necessary. The Department agrees to respond in writing within thirty (30) days of receipt of the original or updated plan, accepting, rejecting, or requesting modifications. In the event of an emergency, the Department may exercise oversight authority over such Provider in order to assume implementation of agreed emergency relief provisions.

9.3 Support to the Deaf or Hard-of-Hearing

9.3.1 The Provider and its subcontractors shall comply with Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, as implemented by 45 CFR Part 84 (hereinafter referred to as Section 504), the Americans with Disabilities Act of 1990, 42 U.S.C. § 12131, as implemented by 28 CFR Part 35 (hereinafter referred to as ADA), and CFOP 60-10, Chapter 4, entitled Auxiliary Aids and Services for the Deaf or Hard-of-Hearing.

9.3.2 If the Provider or any of its subcontractors employs 15 or more employees, such Provider and subcontractor shall each designate a Single-Point-of-Contact to ensure effective communication with deaf or hard-of-hearing customers or companions in accordance with Section 504 of the ADA, and CFOP 60-10, Chapter 4. The Provider's Single-Point-of-Contact and that of its Subcontractors will process the compliance data into the Department's HHS Compliance reporting Database by the 5th business day of the month, covering the previous month's reporting, and forward confirmation of submission to the Contract Manager. The

name and contact information for the Provider's Single-Point-of-Contact shall be furnished to the Department's Contract Manager within fourteen (14) calendar days of the effective date of this requirement.

9.3.3 The Provider shall, within thirty (30) days of the effective date of this requirement, contractually require that its subcontractors comply with Section 504, the ADA, and CFOP 60-10, Chapter 4. A Single-Point-of-Contact shall be required for each subcontractor that employs 15 or more employees. This Single-Point-of-Contact will ensure effective communication with deaf or hard-of-hearing customers or companions in accordance with Section 504 and the ADA and coordinate activities and reports with the Provider's Single-Point-of-Contact.

9.3.4 The Single-Point-of-Contact shall ensure that employees are aware of the requirements, roles and responsibilities, and contact points associated with compliance with Section 504, the ADA, and CFOP 60-10, Chapter 4. Further, employees of providers and their subcontractors with fifteen (15) or more employees shall attest in writing that they are familiar with the requirements of Section 504, the ADA, and CFOP 60-10, Chapter 4. This attestation shall be maintained in the employee's personnel file.

9.3.5 The Provider's Single-Point-of-Contact will ensure that conspicuous Notices which provide information about the availability of appropriate auxiliary aids and services at no-cost to the deaf or hard-of-hearing customers or companions are posted near where people enter or are admitted within the agent locations. Such Notices must be posted immediately by The Provider and its subcontractors. The approved Notice is available at: http://www.myflfamilies.com/about-us/services-deaf-and-hard-hearing/dcf-posters.

9.3.6 The Provider and its subcontractors shall document the customer's or companion's preferred method of communication and any requested auxiliary aids/services provided in the customer's record. Documentation, with supporting justification, must also be made if any request was not honored. The Provider shall distribute Customer Feedback forms to customers or companions, and provide assistance in completing the forms as requested by the customer or companion.

9.3.7 If customers or companions are referred to other agencies, the Provider must ensure that the receiving agency is notified of the customer's or companion's preferred method of communication and any auxiliary aids/service needs.

9.3.8 The Department requires each contract/subcontract provider agency's direct service employees to complete training on serving our Customers who are Deaf or Hard-of-Hearing and sign the Attestation of Understanding. Direct service employees performing under this Contract will also print their certificate of completion, attach it to their Attestation of Understanding, and maintain them in their personnel file.

9.4 Confidential Client and Other Information

Except as provided in this Contract, the Provider shall not use or disclose but shall protect and maintain the confidentiality of any client information and any other information made confidential by Florida law or Federal laws or regulations that is obtained or accessed by the Provider or its subcontractors incidental to performance under this Contract.

9.4.1 State laws providing for the confidentiality of client and other information include but are not limited to sections 39.0132, 39.00145, 39.202, 39.809, 39.908, 63.162, 63.165, 383.412, 394.4615, 397.501, 409.821, 409.175, 410.037, 410.605, 414.295, 415.107, 741.3165 and 916.107, F.S.

9.4.2 Federal laws and regulations to the same effect include section 471(a)(8) of the Social Security Act, section 106(b)(2)(A)(viii) of the Child Abuse Prevention and Treatment Act, 7 U.S.C. § 2020(e)(8), 42 U.S.C. § 602 and 2 CFR § 200.303 and 2 CFR § 200.337, 7 CFR § 272.1(c), 42 CFR §§ 2.1-2.3, 42 CFR §§ 431.300-306, 45 CFR § 205.

9.4.3 A summary of Florida Statutes providing for confidentiality of this and other information are found in Part II of the Attorney General's Government in the Sunshine Manual, as revised from time-to-time.

9.5 Major Disasters and Emergencies

The Stafford Act allows federal assistance for major disasters and emergencies upon a declaration by the President. Upon the declaration, the Department is authorized to apply for federal reimbursement from the Federal Emergency Management Agency (FEMA) to aid in response and recovery from a major disaster. The Provider shall request reimbursement for eligible expenses through the Department and payment will be issued upon FEMA approval and reimbursement.

By signing this Contract, the parties agree that they have read and agree to the entire Contract, as described in Section 1.4.

IN WITNESS THEREOF, the parties hereto have caused this **90** page Contract to be executed by their undersigned officials as duly authorized.

PROVIDER: Broward Behavioral Health Coalition, Inc.

Signature: _____
Print/Type Name: Nan Rich
Title: Chairperson of the Board
Date: _____

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES

Signature: _____
Print/Type Name: Chad Poppell
Title: Secretary
Date: _____

The parties agree that any future amendment(s) replacing this page will not affect the above execution.

Federal Tax ID # (or SSN): **453675836**

Provider Fiscal Year Ending Date: **06/30**.

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EXHIBIT A – SPECIAL PROVISIONS

The following provisions supplement or modify the provisions of Items 1 through 9, as provided herein:

A-1 ENGAGEMENT, TERM AND CONTRACT DOCUMENT

A-1.1 Contract Document

In addition to the provisions of **Section 1.4.**, the following documents, or the latest revisions thereof, are incorporated herein and made a part of this Contract.

A-1.1.1 Additional Contract Exhibits

Exhibits A1, A2, B1, C1, C2, C3, F1 and F2

A-1.1.2 Guidance Documents

Guidance 1 - Evidence-Based Guidelines

Guidance 2 - Tangible Property Requirements

Guidance 3 - Managing Entity Expiration, Termination and Transition Planning Requirements

Guidance 4 - Care Coordination

Guidance 5 - Residential Mental Health Treatment for Children and Adolescents

Guidance 6 - Outpatient Forensic Mental Health Services

Guidance 7 - State Mental Health Treatment Facility Admission and Discharge Processes

Guidance 8 - Assisted Living Facilities with Limited Mental Health (ALF-LMH) Licensure

Guidance 9 - Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach Access, and Recovery (SOAR)

Guidance 10 - Prevention Services

Guidance 11 - Juvenile Incompetent to Proceed (JITP)

Guidance 12 - Behavioral Health Network (BNet) Guidelines and Requirements

Guidance 13 - Indigent Drug Program (IDP)

Guidance 14 - Prevention Partnership Grants (PPG)

Guidance 15 - Projects for Assistance in Transition from Homelessness (PATH)

Guidance 16 - Florida Assertive Community Treatment (FACT) Handbook

Guidance 17 - Temporary Assistance for Needy Families (TANF) Funding Guidance

Guidance 18 - Family Intensive Treatment (FIT) Model Guidelines and Requirements

Guidance 19 - Integration with Child Welfare

Guidance 20 - Local Review Team

Guidance 21 - Housing Coordination

Guidance 22 - Federal Grant Financial Management Requirements

Guidance 23 - Crisis Counseling Program

Guidance 24 - Performance Outcomes Measurement Manual

Guidance 25 - National Voter Registration Act Guidance

Guidance 26 - Women's Special Funding, Substance Abuse Services for Pregnant Women and Mothers

Guidance 27 – Central Receiving Systems Grant

Guidance 28 – Forensic Multidisciplinary Team

Guidance 29 – Transitional Voucher

Guidance 30 – Partnerships for Success (PFS)

Guidance 31 – Children's Mental Health System of Care (CMHSOC) Grant

Guidance 32 – Community Action Treatment (CAT) Team

Guidance 33 – HIV Early Intervention Services

A-1.1.3 Templates

Template 1 - Provider Tangible Property Inventory Form

Template 2 - SAMH Block Grant Reporting Template Overview and Instructions

Template 3 - Narrative Report for the Substance Abuse and Mental Health Block Grant

Template 4 - Managing Entity Annual Business Operations Plan

Template 5 - ALF-LMH Forms

Template 6 - BNet Participant Forms

Template 7 - BNet Alternative Service Forms

Template 8 – *Deleted, effective 11/29/2016*

Template 9 - Local Match Calculation Form

Template 10 - Managing Entity Monthly Fixed Payment Invoice

Template 11 - Managing Entity Monthly Progress Report

Template 12 - Managing Entity Monthly Expenditure Report

Template 13 - *Managing Entity Monthly Carry Forward Expenditure Report*

Template 14 - Cost Allocation Plan

Template 15 - Managing Entity Spending Plan for Carry Forward Report

Template 16 - Women's Special Funding Reporting Template

Template 17 - FIT Reporting Template

Template 18 - *Deleted, effective 5/18/2017*

Template 19 – Partnerships for Success Grant Drug Epidemiology Network (DENs) Report

Template 20 – CMHSOC Quarterly Report Template

Template 21 – Monthly Care Coordination Report

Template 22 – Forensic Diversion Report

Template 23 – Conditional Release Report

Template 24 – Disaster Behavioral Health (DBH) Managing Entity Supplemental Invoice and

Expenditure Report

Template 25 – Forensic Multidisciplinary Team Report

Template 26 – Regional Action Steps to Forensic Goals

Template 27 – Quarterly School-Based Prevention Program Report

A-1.1.4 Financial and Services Accountability Management System (FASAMS) Pamphlet 155-2, available at:

https://www.myflfamilies.com/service-programs/samh/155-2/pamphlet-155-2-v13.shtml

A-1.1.5 Unless otherwise specified in this Contract, all documents incorporated by reference may be located at the following Department webpage location:

https://www.myflfamilies.com/service-programs/samh/managing-entities/

A-1.1.6 Copies of these documents may also be obtained from the Department, 1317 Winewood Boulevard, Tallahassee, FL, 32399-0700.

A-1.2 Program Specific Terms

In addition to the provisions of **Section 1.4.1.**, the definitions in **Exhibit A1** apply to this Contract.

A-2 STATEMENT OF WORK

There are no additional provisions to this section of the Contract.

A-3 PAYMENT, INVOICE AND RELATED TERMS

There are no additional provisions to this section of the Contract.

A-4 GENERAL TERMS AND CONDITIONS GOVERNING PERFORMANCE

A-4.1 Notwithstanding the terms of **Section 4.3.**, the Managing Entity may subcontract with Network Service Providers without advance approval in writing by the Department.

A-4.2 Insurance

In addition to the provisions of **Section 4.5.**, the following Special Insurance Provisions shall apply to this Contract. In the event of any inconsistency between the requirements of this section and the requirements of **Section 4.5.**, the provisions of this section shall prevail and control.

A-4.2.1 The Managing Entity shall notify the Contract Manager within 30 calendar days if there is a modification to the terms of insurance including but not limited to, cancellation or modification to policy limits.

A-4.2.2 The Managing Entity acknowledges that, as an independent contractor, the Managing Entity and its Network Service Providers at all tiers are not covered by the State of Florida Risk Management Trust Fund for liability created by s. 284.30, F.S.

A-4.2.3 The Managing Entity shall obtain and provide proof to the Department of comprehensive general liability insurance coverage (broad form coverage), specifically including premises, fire and legal liability to cover managing the Managing Entity and all its employees. The limits of Managing Entity's coverage shall be no less than $300,000 per occurrence with a minimal annual aggregate of no less than $1,000,000.

A-4.2.4 With the exception of any state agency or subdivision as defined by s. 768.28(2), F.S., the Managing Entity shall cause all Network Service Providers, at all tiers, who the Managing Entity reasonably determines to present a risk of significant loss to the Managing Entity or the Department, to obtain and provide proof to Managing Entity and the Department of comprehensive general liability

insurance coverage (broad form coverage), specifically including premises, fire and legal liability covering the Network Service Provider and all its employees. The limits of coverage for the Managing Entity's Network Service Providers, at all tiers, shall be in such amounts as the Managing Entity reasonably determines to be sufficient to cover the risk of loss.

A-4.2.5 If any officer, employee, or agent of the Managing Entity operates a motor vehicle in the course of the performance of its duties under this contract, the Managing Entity shall obtain and provide proof to the Department of comprehensive automobile liability insurance coverage. The limits of the Managing Entity's coverage shall be no less than $300,000 per occurrence with a minimal annual aggregate of no less than $1,000,000.

A-4.2.6 If any officer, employee, or agent of any Network Service Provider, at all tiers, operates a motor vehicle in the course of the performance of the duties of the Network Service Provider, the Managing Entity shall cause the Network Service Provider to obtain and provide proof to the Managing Entity and the Department of comprehensive automobile liability insurance coverage with the same limits.

A-4.2.7 The Managing Entity shall obtain and provide proof to the Department of professional liability insurance coverage, including errors and omissions coverage, to cover the Managing Entity and all its employees. If any officer, employee, or agent of the Managing Entity administers any prescription drug or medication or controlled substance in the course of the performance of the duties of the Managing Entity under this contract, the professional liability coverage shall include medical malpractice liability and errors and omissions coverage, to cover the Managing Entity and all its employees. The limits of the coverage shall be no less than $300,000 per occurrence with a minimal annual aggregate of no less than $1,000,000.

A-4.2.8 If any officer, employee, or agent of the Network Service Provider, at all tiers, provides any professional services or provides or administers any prescription drug or medication or controlled substance in the course of the performance of the duties of the Network Service Provider, the Managing Entity shall cause the Network Service Provider, at all tiers, to obtain and provide proof to the Managing Entity and the Department of professional liability insurance coverage, including medical malpractice liability and errors and omissions coverage, to cover all Network Service Provider employees with the same limits.

A-4.2.9 The Department shall be exempt from, and in no way liable for, any sums of money that may represent a deductible or self-insured retention under any such insurance. The payment of any deductible on any policy shall be the sole responsibility of the Managing Entity, or Network Service Provider purchasing the insurance.

A-4.2.10 All such insurance policies of the Managing Entity and its Network Service Providers, at all tiers, shall be provided by insurers licensed or eligible to do and that are doing business in the State of Florida. Each insurer must have a minimum rating of "A" by A. M. Best or an equivalent rating by a similar insurance rating firm, and shall name the Department as an additional insured under the policy or policies. The Managing Entity shall use its best good faith efforts to cause the insurers issuing all such general, automobile, and professional liability insurance to use a policy form with additional insured provisions naming the Department as an additional insured or a form of additional insured endorsement that is acceptable to the Department in the reasonable exercise of its judgment.

A-4.2.11 All such insurance proposed by the Managing Entity shall be submitted to and confirmed by the Contract Manager annually by March 31.

A-5 RECORDS, AUDITS AND DATA SECURITY

A-5.1 Inspections and Corrective Action

In addition to the terms of **Section 5.2.**, the following requirements shall apply to this Contract.

A-5.1.1 The Managing Entity shall be monitored in accordance with s. 402.7305, F.S., and CFOP 75-8, Policies and Procedures of Contract Oversight. The Managing Entity shall comply with any requests made by the Department as part of the conduct of such monitoring. At no cost to the Department, the Managing Entity shall provide complete access to all programmatic, administrative, management, budget and financial information related to services provided under this contract.

A-5.1.2 The Department will provide a written report to the Managing Entity within 30 days of the monitoring team's exit. If the report indicates corrective action is necessary, the Managing Entity shall provide a proposed corrective action plan for the Department's approval, except in the case of threat to life or safety of Individuals Served, in which case the Managing Entity shall take immediate action to ameliorate the threat and associated causes.

A-5.1.3 The Managing Entity shall cooperate at all times with the Department to conduct these reviews and shall provide all documentation requested by the reviewers in a timely manner at its administrative office or other location, as determined by the Department.

A-6 PENALTIES, TERMINATION AND DISPUTE RESOLUTION

A-6.1 Termination

The provisions of **Section 6.2.1.** and **Section 6.2.2.** are hereby modified and superseded as follows. The remaining clauses of **Section 6** remain in effect.

A-6.1.1 Notwithstanding the provisions of **Section 6.2.1.**, in accordance with Section 22 of PUR 1000 Form, this Contract may be terminated by the Department without cause upon no less than 180 calendar days' notice in writing to the Provider unless a sooner time is mutually agreed upon in writing.

A-6.1.2 Notwithstanding the provisions of **Section 6.2.2.**, this Contract may be terminated by the Provider upon no less than 180 calendar days' notice in writing to the Department unless a sooner time is mutually agreed upon in writing.

A-6.2 Dispute Resolution

In addition to the terms of **Section 6.3.**, the following Dispute Resolution terms shall apply to this Contract:

A-6.2.1 The parties agree to cooperate in resolving any differences in interpreting the contract. Within five working days of the execution of this contract, each party shall designate one person with the requisite authority to act as its representative for dispute resolution purposes. Each party shall notify the other party of the person's name and business address and telephone number. Within five working days from delivery to the designated representative of the other party of a written request for dispute resolution, the representatives will conduct a face-to-face meeting to resolve the disagreement amicably. If the representatives are unable to reach a mutually satisfactory resolution, either representative may request referral of the issue to the Managing Entity's Chief Executive Officer (CEO) and the Department's Regional Managing Director (RMD). Upon referral to this second step, the respective parties shall confer in an attempt to resolve the issue.

A-6.2.2 If the CEO and RMD are unable to resolve the issue within 10 days, the parties' appointed representatives shall meet within 10 working days and select a third representative. These three representatives shall meet within 10 working days to seek resolution of the dispute. If the representatives' good faith efforts to resolve the dispute fail, the representatives shall make written recommendations to the Secretary who will work with both parties to resolve the dispute. The parties reserve all their rights and remedies under Florida law. Venue for any court action will be in Leon County, Florida.

A-7 OTHER TERMS

A-7.1 The Managing Entity shall comply with all applicable federal and state laws and regulations and all policies, directives and guidelines published by the Department. In the event the Department amends any policies, directives, or guidelines after contract execution, the Department will provide electronic notice to the Managing Entity.

A-7.2 **Exhibit A2** contains additional state and federal laws, rules, and regulations applicable to performance under this Contract.

A-8 FEDERAL FUNDS APPLICABILITY

There are no additional provisions to this section of the Contract.

A-9 CLIENT SERVICES APPLICABILITY

There are no additional provisions to this section of the Contract.

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EXHIBIT A1 – PROGRAM AND SERVICE SPECIFIC TERMS

A1-1 Behavioral Health Network (BNet)

A statewide network of Behavioral Health Service providers which serve children with mental health or substance use disorders who are ineligible for Medicaid and are determined eligible for Title XXI of the United States Public Health Services Act.

A1-2 Behavioral Health Services

As defined by s. 394.9082(2)(a), F.S.

A1-3 Block Grants

The Community Mental Health Block Grant (CMHBG), pursuant to 42 U.S.C. s. 300x, et seq.; and the Substance Abuse Prevention and Treatment Block Grant (SAPTBG), pursuant to 42 U.S.C. s. 300x-21, et seq.

A1-4 Continuous Quality Improvement (CQI)

An ongoing, systematic process of internal and external improvements in service provision and administrative functions, taking into account both in process and end of process indicators, in order to meet the valid requirements of Individuals Served.

A1-5 Coordinated System of Care

As defined by s. 394.9082(2)(b), F.S.

A1-6 Electronic Health Record (EHR)

As defined by s. 408.051(2)(a), F.S.

A1-7 Electronic Vault

An information technology system designed to store, manage, and track electronic versions of original and scanned documents, and to provide remote document access to Department staff.

A1-8 Evidence-Based Practice (EBP)

As defined by **Guidance 1 – Evidence-Based Guidelines.**

A1-9 Indigent Psychiatric Medication Program, also known as the Indigent Drug Program (IDP)

Behavioral Health Services provided pursuant to s. 394.676, F.S.

A1-10 Individual(s) Served

An individual who receives substance abuse or mental health services, the cost of which is paid, either in part or whole, by Department appropriated funds or local match (matching).

A1-11 Juvenile Incompetent to Proceed (JITP)

"Child," "juvenile" or "youth" as defined by s. 985.03(7), F.S., deemed incompetent to proceed for accused crimes pursuant to s. 985.19, F.S.

A1-12 Local Match

Pursuant to s. 394.74(2)(b), F.S., and s. 394.76, F.S.

A1-13 Managing Entity

As defined by s. 394.9082(2)(e), F.S. Throughout this Contract, the term Managing Entity is synonymous with the definition of Provider in the Department's Standard Contract.

A1-14 Mental Health Services

As defined by s. 394.67(15), F.S.

A1-15 Network Service Provider(s)

A direct service agency providing Substance Abuse or Mental Health Services that is under contract with a Managing Entity, and referred to collectively as the "Network." The Network shall consist of a comprehensive array of Behavioral Health Services and programs that are designed to meet the local need, are accessible and responsive to the needs of Individuals Served, their families, and community stakeholders, and include the essential elements of a coordinated system of care specified in s. 394.4573(2), F.S.

A1-16 Operational Costs

The allowable expenses incurred by a Managing Entity in performing its contracted functions and delivering its contracted services.

A1-17 Projects for Assistance in Transition from Homelessness (PATH)

A federal grant to support homeless individuals with mental illnesses, who may also have co-occurring substance abuse and mental health treatment needs.

A1-18 Risk Assessment

A process for evaluating the threat of damage, loss, liability, or other negative occurrence caused by external or internal vulnerabilities that may be avoided through pre-emptive action. An effective Risk Assessment prioritizes the extent and degree of appropriate monitoring activities.

A1-19 Safety Net

The publicly funded Behavioral Health Services and providers that have either historically received or currently receive funding appropriated to the Department by the General Appropriations Act (GAA). The Safety Net is intended to provide funding to Network Service Providers for expenditures that would otherwise be uncompensated costs for services provided to individuals in need of services.

A1-20 Stakeholders

Individuals or groups with an interest in the provision of treatment or prevention services to individuals with substance use, mental health, and co-occurring disorders in the county(ies) specified in **Section B-3.1.** This includes, but is not limited to, the key community constituents included in s. 394.9082(5), F.S.

A1-21 State Mental Health Treatment Facilities

State Mental Health Treatment Facilities serving adults who have been committed for intensive inpatient treatment by a circuit court and pursuant to Chapter 394, F.S. or Chapter 916, F.S.

A1-22 Statewide Inpatient Psychiatric Programs (SIPP)

Medicaid-funded services to children under age 18 provided in a residential treatment center or hospital, licensed by the Agency for Health Care Administration (AHCA), which provides diagnostic and active treatment services in a secure setting. SIPP providers must be under contract with AHCA and provide these services in accordance with Chapter 394, F.S., Chapter 408, F.S., Chapter 409, F.S., and Rule 65E-9.008(4), F.A.C.

A1-23 Submit

Unless otherwise specified, the term "Submit" as used in this Contract shall be construed to mean submission of a contractual requirement to the Department's Contract Manager, subject to the provisions of **Section C-2.4.7.**

A1-24 Substance Abuse and Mental Health Data System (SAMH Data System)

Collectively, the Department's web-based data systems for reporting substance abuse and mental health services, including the Substance Abuse and Mental Health Information System (SAMHIS), the Performance Based

Prevention System (PBPS), the Financial and Service Accountability Management System (FASAMS) or any replacement systems identified by the Department for the reporting of data by the Managing Entity and all Network Service Providers in accordance with this contract.

A1-25 Substance Abuse Services

Any of the substance abuse prevention, intervention and clinical treatment services defined in s. 397.311(26), F.S.

A1-26 Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) Outreach, Access, and Recovery (SOAR)

A Substance Abuse and Mental Health Services Administration (SAMHSA) technical assistance initiative designed to help individuals increase earlier access to SSI and SSDI through improved approval rates on initial Social Security applications by providing training, technical assistance, and strategic planning to Network Service Providers.

A1-27 Temporary Assistance to Needy Families (TANF)

As defined by 42 U.S.C. ss. 601, et seq., and Chapter 414, F.S.

A1-28 Wait List

A master list for the Network, maintained by a Managing Entity that shows:

A1-28.1 The number of individuals waiting for access to the recommended service or program;

A1-28.2 The length of time each individual has been on the waiting list; and

A1-28.3 The interim services provided to the individual.

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EXHIBIT A2 – SAMH PROGRAMMATIC STATE AND FEDERAL LAWS, RULES, AND REGULATIONS

The provider and its subcontractors shall comply with all applicable state and federal laws, rules and regulations, as amended from time to time, that affect the subject areas of the contract. Authorities include but are not limited to the following:

A2-1 Federal Authority

A2-1.1 Block Grants Regarding Mental Health and Substance Abuse

A2-1.1.1 Block Grants for Community Mental Health Services

42 U.S.C. ss. 300x, et seq.

A2-1.1.2 Block Grants for Prevention and Treatment of Substance Abuse

42 U.S.C. ss. 300x-21 et seq.

45 CFR Part 96, Subpart L

A2-1.2 Department of Health And Human Services, General Administration, Block Grants

45 CFR Part. 96

A2-1.3 Charitable Choice Regulations Applicable to Substance Abuse Block Grant and PATH Grant

42 CFR Part 54

A2-1.4 Confidentiality Of Substance Use Disorder Patient Records

42 CFR Part 2

A2-1.5 Security and Privacy

45 CFR Part 164

A2-1.6 Supplemental Security Income for the Aged, Blind and Disabled

20 CFR Part 416

A2-1.7 Temporary Assistance to Needy Families (TANF)

42 U.S.C. ss. 601 - 619

45 CFR, Part 260

A2-1.8 Projects for Assistance in Transition from Homelessness (PATH)

42 U.S.C. ss. 290cc-21 – 290cc-35

A2-1.9 Equal Opportunity for Individuals with Disabilities (Americans with Disabilities Act of 1990)

42 U.S.C. ss. 12101 - 12213

A2-1.10 Prevention of Trafficking (Trafficking Victims Protection Act of 2000)

22 U.S.C. s. 7104

2 CFR Part 175

A2-1.11 Governmentwide Requirements for Drug-Free Workplace (Financial Assistance)

2 CFR Part 182

2 CFR Part 382

A2-2 Florida Statutes

A2-2.1 Child Welfare and Community Based Care

Ch. 39, F.S.	Proceedings Relating to Children
Ch. 402, F.S.	Health and Human Services: Miscellaneous Provisions

A2-2.2 Substance Abuse and Mental Health Services

Ch. 381, F.S.	Public Health: General Provisions
Ch. 386, F.S.	Particular Conditions Affecting Public Health
Ch. 394, F.S.	Mental Health
Ch. 395, F.S.	Hospital Licensing and Regulation
Ch. 397, F.S.	Substance Abuse Services
Ch. 400, F.S.	Nursing Home and Related Health Care Facilities
Ch. 414, F.S.	Family Self-Sufficiency
Ch. 458, F.S.	Medical Practice
Ch. 464, F.S.	Nursing
Ch. 465, F.S.	Pharmacy
Ch. 490, F.S.	Psychological Services
Ch. 491, F.S.	Clinical, Counseling, and Psychotherapy Services
Ch. 499, F.S.	Florida Drug and Cosmetic Act
Ch. 553, F.S.	Building Construction Standards
Ch. 893, F.S.	Drug Abuse Prevention and Control
S. 409.906(8), F.S.	Optional Medicaid Services – Community Mental Health Services

A2-2.3 Developmental Disabilities

Ch. 393, F.S.	Developmental Disabilities

A2-2.4 Adult Protective Services

Ch. 415, F.S.	Adult Protective Services

A2-2.5 Forensics

Ch. 916, F.S.	Mentally Ill And Intellectually Disabled Defendants
Ch. 985, F.S.	Juvenile Justice; Interstate Compact on Juveniles
S. 985.19, F.S.	Incompetency in Juvenile Delinquency Cases
S. 985.24, F.S.	Use of detention; prohibitions

A2-2.6 State Administrative Procedures and Services

Ch. 119, F.S.	Public Records
Ch. 120, F.S.	Administrative Procedures Act
Ch. 287, F.S.	Procurement of Personal Property and Services
Ch. 435, F.S.	Employment Screening

Ch. 815, F.S.	Computer-Related Crimes
Ch. 817, F.S.	Fraudulent Practices
S. 112.061, F.S.	Per diem and travel expenses of public officers, employees, and authorized persons
S. 112.3185, F.S.	Additional standards for state agency employees
S. 215.422, F.S.	Payments, warrants, and invoices; processing time limits; dispute resolution; agency or judicial branch compliance
S. 216.181(16)(b), F.S.	Advanced funds for program startup or contracted services

A2-3 Florida Administrative Code

A2-3.1 Child Welfare and Community Based Care

Ch. 65C-13, F.A.C.	Foster Care Licensing
Ch. 65C-14, F.A.C.	Child-Caring Agency Licensing
Ch. 65C-15, F.A.C.	Child-Placing Agencies

A2-3.2 Substance Abuse and Mental Health Services

Ch. 65D-30, F.A.C.	Substance Abuse Services Office
Ch. 65E-4, F.A.C.	Community Mental Health Regulation
Ch. 65E-5, F.A.C.	Mental Health Act Regulation
Ch. 65E-10, F.A.C.	Psychotic and Emotionally Disturbed Children - Purchase of Residential Services Rules
Ch. 65E-11, F.A.C.	Behavioral Health Services
Ch. 65E-12, F.A.C.	Public Mental Health Crisis Stabilization Units and Short Term Residential Treatment Programs
Ch. 65E-14, F.A.C.	Community Substance Abuse and Mental Health Services - Financial Rules
Ch. 65E-20, F.A.C.	Forensic Client Services Act Regulation
Ch. 65E-26, F.A.C.	Substance Abuse and Mental Health Priority Populations and Services

A2-3.3 Financial Penalties

Ch. 65-29, F.A.C.	Penalties on Service Providers

A2-4 MISCELLANEOUS

A2-4.1 Department of Children and Families Operating Procedures

CFOP 155-10 / 175-40	Services for Children with Mental Health and Any Co-Occurring Substance Abuse or Developmental Disability Treatment Needs in Out-of-Home Care Placements
CFOP 155-11	Title XXI Behavioral Health Network
CFOP 155-47	Processing Referrals From The Department Of Corrections
CFOP 215-6	Incident Reporting and Analysis System (IRAS)

A2-4.2 Standards applicable to Cost Principles, Audits, Financial Assistance and Administrative Requirements

S. 215.425, F.S.	Extra Compensation Claims prohibited; bonuses; severance pay
S. 215.97, F.S.	Florida Single Audit Act
S. 215.971, F.S.	Agreements funded with federal or state assistance
Ch. 69I-42, F.A.C.	Travel Expenses
Comptroller's Memorandum No. 03 (1999-2000)	Florida Single Audit Act Implementation
CFO's Memorandum No. 03 (2014 - 2015)	Compliance Requirements for Agreements
2 CFR, Part 180	Office of Management and Budget Guidelines to Agencies on Government Wide Debarment and Suspension (Non-procurement),
2 CFR, Part 200	Office of Management and Budget Guidance - Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, available at https://federalregister.gov/a/2013-30465
2 CFR, Part 300	Department of Health and Human Services - Office of Management and Budget Guidance - Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, Adoption of 2 CFR Part 200
45 CFR, Part 75	Uniform Administration Requirements, Cost Principles, and Audit Requirements for HHS Awards

A2-4.3 Data Collection and Reporting Requirements

S. 394.74(3)(e), F.S.	Data Submission
S. 394.9082, F.S.	Behavioral health managing entities
S. 394.77, F.S.	Uniform management information, accounting, and reporting systems for providers
S. 397.321(3)(c), F.S.	Data collection and dissemination system
DCF PAM 155-2	Mental Health and Substance Abuse Measurement and Data

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EXHIBIT B – SCOPE OF WORK

B-1 Scope of Service

The Managing Entity shall be responsible for the planning, coordination, and subcontracting of the Provider Network, as defined by s. 394.9082(2)(f), F.S., thereby providing a comprehensive array of Behavioral Health Services to individuals, including emergency, acute care, residential, outpatient, recovery support, consumer support and prevention services.

B-2 Major Contract Goals

The Department is contracting with the Managing Entity, pursuant to s. 394.9082, F.S., to plan, coordinate, and subcontract for the delivery of community mental health and substance abuse services; to improve access to care and promote service continuity; and to support efficient and effective delivery of services.

B-3 Service Area and Locations

B-3.1 The Managing Entity shall subcontract for services within the following county: Broward.

B-3.2 When needed, the Managing Entity may subcontract for residential services related to the Purchase of Residential Treatment Services (PRTS) for emotionally disturbed children and youth in additional Florida counties, subject to advance written approval of each subcontractor by the Department.

B-3.3 The Managing Entity shall maintain an administrative office within the service area defined in **Section B-3.1** and shall subcontract with Network Services Providers operating within the same area.

B-3.4 The Managing Entity shall notify the Department's Contract Manager, in writing, at least 10 calendar days prior to any changes in locations where services are being provided.

B-3.5 The Managing Entity shall notify the Department in writing a minimum of 30 days prior to making changes in location that will affect the Department's ability to contact the Managing Entity by telephone or facsimile transmission.

B-4 Individuals to Be Served

The Managing Entity shall contract with Network Service Providers for Behavioral Health Services provided to individuals as detailed in **Section B-5.** Contracts with Network Service Providers shall include compliance with the Department's requirements for Individuals Served.

B-5 Client Eligibility

Behavioral Health services shall be provided to persons pursuant to s. 394.674, F.S., including those individuals who have been identified as requiring priority by state or federal law. These identified priorities include, but are not limited to, the categories in **Sections B-5.1** through **B-5.10.** Persons in **Sections B-5.1** through **B-5.2** are specifically identified as persons to be given immediate priority over those in any other sections.

B-5.1 Pursuant to 45 CFR s. 96.131, priority admission to pregnant women and women with dependent children by Network Service Providers receiving SAPT Block Grant funding;

B-5.2 Pursuant to 45 CFR s. 96.126, compliance with interim services, for injection drug users, by Network Service Providers receiving SAPT Block Grant funding and treating injection drug users;

B-5.3 Priority for services to families with children that have been determined to require substance abuse and mental health services by child protective investigators and also meet the target populations in **Section B-5.3.1** or **Section B-5.3.2.** Such priority shall be limited to individuals that are not enrolled in Medicaid or another insurance program, or require services that are not paid by another payor source:

B-5.3.1 Parents or caregivers in need of adult mental health services pursuant to s. 394.674(1)(a)2., F.S., based upon the emotional crisis experienced from the potential removal of children; or

B-5.3.2 Parents or caregivers in need of adult substance abuse services pursuant to s. 394.674(1)(c)3., F.S., based on the risk to the children due to a substance use disorder.

B-5.4 Individuals who reside in civil and forensic State Mental Health Treatment Facilities and individuals who are at risk of being admitted into a civil or forensic State Mental Health Treatment Facility;

B-5.5 Individuals who are voluntarily admitted, involuntarily examined, or placed under Part I, Chapter 394, F.S.;

B-5.6 Individuals who are involuntarily admitted under Part V, Chapter 397, F.S.;

B-5.7 Residents of assisted living facilities as required in ss. 394.4574 and 429.075, F.S.;

B-5.8 Children referred for residential placement in compliance with Ch. 65E-9.008, F.A.C

B-5.9 Inmates approaching the End of Sentence pursuant to Children and Families Operating Procedure (CFOP) 155-47: "Processing Referrals from the Department of Corrections;" and

B-5.10 In the event of a Presidential Major Disaster Declaration, Crisis Counseling Program (CCP) services shall be contracted for according to the terms and conditions of any CCP grant award approved by representatives of the Federal Emergency Management Agency (FEMA) and the Substance Abuse and Mental Health Services Administration (SAMHSA).

B-6 Client Determination

B-6.1 The Managing Entity may delegate determinations to the Network Service Providers, subject to the provisions of **Section B-6.4.**

B-6.2 In no circumstances shall an individual's county of residence be a factor that denies access to service.

B-6.3 The Managing Entity shall require each Network Service Provider submit a monthly attestation attached to an invoice to the Managing Entity, declaring that, at the time of submission, no other funding source was known for the invoiced services.

B-6.4 The Department, in accordance with state law, is exclusively responsible for defining Individuals Served for services provided through this Contract. In the event of a dispute, the determination made by the Department is final and binding on all parties.

B-7 Equipment

B-7.1 The Managing Entity and all Network Service Providers shall supply all equipment necessary to provide services and fulfill the terms and conditions of this Contract, including but not limited to; computers, telephones, copier, and fax machines, supplies and maintenance, and necessary office supplies.

B-7.2 The Managing Entity shall ensure that Network Service Providers comply with requirements in the **Guidance 2 – Tangible Property Requirements** and document compliance through the submission of **Template 1 – Provider Tangible Property Inventory Form.**

B-8 Contract Limits

B-8.1 The Department's obligation to pay for services provided under this Contract is expressly limited by the availability of funds and subject to annual appropriations by the Legislature.

B-8.2 The Managing Entity is expressly prohibited from authorizing or incurring indebtedness on behalf of the Department.

B-8.3 The Managing Entity is expressly prohibited from utilizing accounting practices or redirecting funds to circumvent legislative intent.

B-8.4 Services shall only be provided within the service area outlined in **Section B-3.1.**

B-8.5 Pursuant to 45 CFR §96.135(a)(5), the Managing Entity may not enter into subcontracts with a for-profit entity using Block Grant funds unless the for-profit entity subcontract is solely for providing goods and services for the Managing Entity's own use in meeting its obligations under this Contract. A subcontract with a for-profit entity may not provide for services meeting the definition of a "subaward" as defined in 2 CFR §200.92, using Block Grant funds.

B-8.6 The Managing Entity shall not subcontract development, implementation, administrative, or monitoring responsibilities without prior written approval from the Department.

B-8.7 The Managing Entity shall not subcontract for Behavioral Health Services with any person or entity which:

B-8.7.1 Is barred, suspended, or otherwise prohibited from doing business with any government entity, or has been barred, suspended, or otherwise prohibited from doing business with any government entity in accordance with s. 287.133, F.S.;

B-8.7.2 Is under investigation or indictment for criminal conduct, or has been convicted of any crime which would adversely reflect on its ability to provide services, or which adversely reflects its ability to properly handle public funds;

B-8.7.3 Has had a contract terminated by the Department for failure to satisfactorily perform or for cause;

B-8.7.4 Has failed to implement a corrective action plan approved by the Department or any other governmental entity, after having received due notice; or

B-8.7.5 Is ineligible for contracting pursuant to the standards in s. 215.473(2), F.S.

B-8.8 Regardless of the amount of the subcontract, the Managing Entity shall immediately terminate a subcontract for cause, if at any time during the lifetime of the subcontract, a Network Service Provider is:

B-8.8.1 Found to have submitted a false certification under s. 287.135, F.S., or

B-8.8.2 Is placed on the Scrutinized Companies with Activities in Sudan List or

B-8.8.3 Is placed on the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List, or

B-8.8.4 Is placed on the Scrutinized Companies that Boycott Israel List or is engaged in a boycott of Israel.

B-8.9 The Managing Entity agrees that services funded by this Contract other than those set out in this Contract, will be provided only upon receipt of a written authorization from the Contract Manager. The Department has final authority to make any and all determinations that affect the health, safety, and well-being of the people of the State of Florida.

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EXHIBIT B1 – FEDERAL BLOCK GRANT REQUIREMENTS

B1-1 Purpose

B1-1.1 The purpose of this document is to outline the expectations of the Department for the Managing Entity, in relation to the federal Community Mental Health Services (CMHS) block grant, as authorized by 42.U.S.C. s. 300x, and Substance Abuse Prevention and Treatment (SAPT) block grant, as authorized by 42 U.S.C. s. 300x-21.

B1-1.2 Managing Entity Assurance

The Managing Entity shall assume the responsibility of implementation, administration, and monitoring of the CMHS and SAPT block grants, and the associated maintenance of effort requirements.

B1-1.3 The Managing Entity shall ensure that the Department is able to meet the assurances required of the State to the federal government in 45 CFR s. 96.123, to be eligible to receive block grant funding.

B1-1.4 The Managing Entity shall be responsible for the implementation, administration, monitoring, and compliance with the requirements of the Block Grants. The Department will provide technical assistance to the Managing Entity. The Managing Entity agrees that failure to comply with the requirements of these federal Block Grants represents a material breach of this contract and shall subject the Managing Entity to performance deficiencies and financial consequences as specified in **Section 3.4.**

B1-2 Managing Entity Requirements

B1-2.1 The Managing Entity shall report expenditures, service utilization data, demographic information, and national outcome measures as required by the 42.U.S.C. s. 300x and 42 U.S.C. s. 300x-21.

B1-2.2 The Managing Entity shall be responsible for ensuring that the Department can report the following allocations in accordance with the requirements set by federal law:

B1-2.2.1 Of the SAPT block grant:

B1-2.2.1.1 Pursuant to 45 CFR s. 96.124(b), not less than the amount specified in **Exhibit F1** for "Substance Abuse Prevention Services" on primary prevention services for those who do not require treatment;

B1-2.2.1.2 Pursuant to 42 U.S.C. s. 300x-24(b), not less than the amount specified in **Exhibit F1** for "HIV Services" on HIV Early Intervention Services.

B1-2.2.2 Of State funds appropriated to substance abuse treatment for adults, pursuant to 45 CFR s. 96.124(c), not less than the amount specified in **Exhibit F1** for "Projects Expansion of Substance Abuse Services for Pregnant Women and their affected families" on services for pregnant women, and women with dependent children.

B1-2.2.3 Pursuant to 42 U.S.C. s.300x-9(c), of the CMHS block grant, not less than the amount specified in **Exhibit F1** for "ME Early Intervention Services for SMI & Psych Disorder" subcontracted for the Implementation of the Coordinated Specialty Care for Early Serious Mental Illness, including First Episode Psychosis, program to serve a minimum number of individuals annually, as negotiated by the Department based on available funding. The subcontract shall specify standards for implementation and base the program design upon:

B1-2.2.3.1 The NAVIGATE Team Members' Guide, available at http://navigateconsultants.org/manuals/, hereby incorporated by reference, or

B1-2.2.3.2 The OnTrackNY Team Manual, available at http://www.ontrackny.org/Resources, hereby incorporated by reference.

B1-2.2.3.3 The Managing Entity shall adopt mechanisms for ongoing monitoring of the program for fidelity with the selected program design.

B1-2.2.4 Pursuant to 45 CFR s. 96.131, the Managing Entity shall ensure that subcontractors that receive SAPT block grant funding prioritize treatment services for pregnant women. This shall include:

B1-2.2.4.1 The development, implementation, and administration of an electronic waitlist to ensure that providers give preference in admitting people into treatment as follows:

B1-2.2.4.1.1 Pregnant injecting drug users;

B1-2.2.4.1.2 Pregnant drug users;

B1-2.2.4.1.3 People who inject drugs; and

B1-2.2.4.1.4 All others.

B1-2.2.4.2 If the clinically appropriate services cannot be provided for the pregnant woman, interim services shall be provided not later than 48 hours after the woman seeks treatment services.

B1-2.2.4.3 The capacity to track and report the type of service, number of pregnant women served, and amount of services purchased by federal and state sources.

B1-2.2.4.4 Policies and procedures relating to treatment services for pregnant women and, where appropriate, ensure that families are able to remain together when parents require treatment.

B1-2.2.5 Pursuant to 45 CFR s. 96.126, the Managing Entity shall maintain an electronic waitlist for the sub-contractors that receive SAPT block grant funding and serve injection drug users, and ensure the implementation of the 14/120-day requirement of 45 CFR s. 96.126(b), and provide interim services until such time as the clinically appropriate level of treatment can be provided to the individual.

B1-2.2.5.1 Outreach services shall be provided, pursuant to 45 CFR s. 96.126(e), and documented to demonstrate the provision of these services.

B1-2.2.5.2 The Managing Entity shall maintain a report of the Network Service Providers that reach 90% capacity, and the monitoring procedures to ensure that this occurs.

B1-2.2.6 Pursuant to 45 CFR s. 96.125, the Managing Entity shall prepare and implement a comprehensive primary prevention program that uses a variety of strategies.

B1-2.2.7 Pursuant to 45 CFR s. 95.127, the Managing Entity shall ensure the provision of tuberculosis services, in compliance with Ch. 65D-30.004(9). F.A.C.

B1-2.2.8 Pursuant to 45 CFR s. 96.128, the Managing Entity shall ensure the provision of early intervention services for HIV and in compliance with Ch. 65D-30.004(9), F.A.C., and in accordance with **Guidance 33 – HIV Early Intervention Services**.

B1-2.2.9 Pursuant to 45 CFR s. 96.123(a)(7) and s. 96.132(b), the Managing Entity shall ensure that subcontracted Network Service Providers receive continuing education, and this shall be documented to demonstrate the provision of said education.

B1-2.2.10 Pursuant to 45 CFR s.96.123(a)(7) and s. 96.132(a), the Managing Entity shall develop and implement a process for improving referrals of individuals to the treatment modality that is most appropriate for the individuals.

B1-2.2.11 The Managing Entity shall ensure that each year, an evaluation of the procedures and activities undertaken to comply with the block grant requirements shall be completed.

B1-2.2.12 The Managing Entity shall ensure that each year, an assessment of need is undertaken that complies with the requirements of 45 CFR s. 96.133, and 42 U.S.C. s. 300x-1 for adults with a serious mental illness, and children with serious emotional disturbances.

B1-2.2.13 The Managing Entity shall ensure that block grant funding is not expended on the restricted activities pursuant to 45 CFR s. 96.135, 42 U.S.C. s. 300x-5, and 42 U.S.C. s.300x-31. Restricted activities include, but are not necessarily limited to, the following. Managing Entities may consult the Department for technical assistance to address allowability of specific cases before subcontracting.

B1-2.2.13.1 The CMHS block grant and the SAPT block grant may not be used to:

B1-2.2.13.1.1 Provide inpatient hospital services;

B1-2.2.13.1.2 Fund the enforcement of alcohol, tobacco, or drug laws;

B1-2.2.13.1.3 Make cash payments to intended recipients of health services;

B1-2.2.13.1.4 Purchase or improve land; purchase, construct, or permanently improve (other than minor remodeling) any building or other facility; or purchase major medical equipment;

B1-2.2.13.1.5 Satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds;

B1-2.2.13.1.6 Provide financial assistance to any entity other than a public or nonprofit private entity; or

B1-2.2.13.1.7 Provide any services within prisons or jails.

B1-2.2.13.2 Primary prevention set-aside funds from the SAPT block grant may not be used to:

B1-2.2.13.2.1 Provide Screening, Brief Intervention, and Referral to Treatment (SBIRT) programs; or

B1-2.2.13.2.2 Provide Mental Health First Aid or Crisis Intervention Training programs.

B1-2.2.14 Pursuant to 42 U.S.C. s. 300x-3, the Managing Entity shall collaborate with the Department to ensure that members of the planning council are able to undertake their statutory duties. This will include the participation of the Council member at the Managing Entity Board meetings.

B1-3 Monitoring

B1-3.1 The Managing Entity shall implement a monitoring process that will demonstrate oversight and corrective action in the case of non-compliance, for all Network Service Providers that receive block grant funds.

B1-3.2 The Managing Entity shall:

B1-3.2.1 As a component of Network Service Provider monitoring, include oversight of the block grant requirements;

B1-3.2.2 Develop and utilize standardized monitoring tools;

B1-3.2.3 Provide the Department with access to the monitoring reports, via the electronic vault; and

B1-3.2.4 Develop and utilize the monitoring reports to create corrective action plans for Network Service Providers, where necessary.

B1-4 Reporting

B1-4.1 To demonstrate compliance with the requirements of the SAPT and CMHS block grants, the Managing Entity shall, on a quarterly basis report on the following activities:

B1-4.1.1 Training and technical assistance;

B1-4.1.2 Access to treatment for injection drug users, including capacity reports;

B1-4.1.3 Follow-up actions taken in response to findings from peer review activities;

B1-4.1.4 Priority access to treatment for pregnant women;

B1-4.1.5 Wait list management for injection drug users and pregnant women;

B1-4.1.6 Compliance with charitable choice provisions;

B1-4.1.7 Monitoring; and

B1-4.1.8 Continuous quality improvement.

B1-4.2 To meet the reporting requirements of the State to the federal government, the Managing Entity shall complete and submit **Template 2 – SAMH Block Grant Reporting Template** by March 15 and September 1 of each year. This shall be accompanied by a certification of accuracy, from the Chief Executive Officer and Chief Financial Officer, or equivalent positions.

B1-4.3 To meet the reporting requirements of the State to the federal government, the Managing Entity shall complete and submit **Template 3 – Narrative Report for the Substance Abuse and Mental Health Block Grant biennially** by May 30 of each odd-numbered year (i.e., 2021, 2023, 2025, etc.)

B1-5 Elements to be included in subcontracts with Network Service Providers

B1-5.1 The Managing Entity shall ensure that the following are included in subcontracts with appropriate Network Service Providers:

B1-5.1.1 Requirements to ensure compliance with the SAMHSA Charitable Choice provisions and the implementing regulations of 42 CFR s. 54a;

B1-5.1.2 Requirements to ensure that Network Service Providers that receive block grant funds comply with 42 CFR Part 2;

B1-5.1.3 Provisions to monitor block grant requirements, and activities;

B1-5.1.4 Sufficient detail in a Network Service Provider invoice to capture, report, and test the validity of expenditures and service utilization;

B1-5.1.5 For Network Service Providers that receive SAPT block grant funding for the purpose of primary prevention of substance use, compliance with 45 CFR s. 96.125;

B1-5.1.6 An invoice that includes the minimum data elements to satisfy the Department's application and reporting requirements; and

B1-5.1.7 Compliance with state or federal requests for information related to the SAPT and CMHS block grants.

B1-5.1.8 In accordance with 45 CFR ss. 96.131(a) and (b), a requirement that providers that receive Block Grant funds and that serve injection drug users publicize the following notice: "This program receives federal Substance Abuse Prevention and Treatment Block Grant funds and serves

people who inject drugs. This program is therefore federally required to give preference in admitting people into treatment as follows: 1. Pregnant injecting drug users; 2. Pregnant drug users; 3. People who inject drugs; and 4. All others."

B1-5.2 The Managing Entity shall ensure the following are included in all subcontracts with Network Service Providers for treatment services:

B1-5.2.1 A requirement to discuss the option of medication-assisted treatment with individuals with opioid use disorders or alcohol use disorders.

B1-5.2.1.1 For individuals with opioid use disorders, the Network Service Provider shall discuss medication-assisted treatment using FDA-approved medications including but not limited to methadone, buprenorphine, and naltrexone.

B1-5.2.1.2 For individuals with alcohol use disorders, the Network Service Provider shall discuss medication-assisted treatment using FDA-approved medications including but not limited to disulfiram, and acamprosate products.

B1-5.2.2 A requirement to actively link individuals to medication-assisted treatment providers upon request of the individual served;

B1-5.2.3 A prohibition on a denial of an eligible individual's access to the Network Service Provider's program or services based on the individual's current or past use of FDA-approved medications for the treatment of substance use disorders. Specifically, this must include requirements to:

B1-5.2.3.1 Ensure the Network Service Provider's programs and services do not prevent the individual from participating in methadone treatment rendered in accordance with current federal and state methadone dispensing regulations from an Opioid Treatment Program when ordered by a physician who has evaluated the client and determined that methadone is an appropriate medication treatment for the individual's opioid use disorder;

B1-5.2.3.2 Permit the individual to access medications for FDA-approved medication-assisted treatment by prescription or office-based implantation if the medication is appropriately authorized through prescription by a licensed prescriber or provider.

B1-5.2.3.3 Permit continuation in medication-assisted treatment for as long as the prescriber or medication-assisted treatment provider determines that the medication is clinically beneficial; and

B1-5.2.3.4 Prohibit compelling an individual to no longer use medication-assisted treatment as part of the conditions of any program or services if stopping is inconsistent with a licensed prescriber's recommendation or valid prescription.

EXHIBIT C – TASK LIST

C-1 Service Tasks

The Managing Entity shall perform all functions necessary for the proper development, implementation, administration, and monitoring of a behavioral health Safety Net, including, but not limited to, the following functions:

C-1.1 Development and Planning Function

C-1.1.1 The Managing Entity shall develop and manage a comprehensive Network of qualified subcontracted Network Service Providers that:

C-1.1.1.1 Promotes recovery and resiliency;

C-1.1.1.2 Promotes the development and effective implementation of a coordinated system of care;

C-1.1.1.3 Provides an optimal array of services to meet identified community Behavioral Health Service needs;

C-1.1.1.4 Manages and allocates available funds in compliance with federal and state laws, rule and regulations; and

C-1.1.1.5 Is accessible and responsive to individuals, families, and community Stakeholders.

C-1.1.2 The Managing Entity shall participate in community, circuit, regional and state planning in accordance with s. 394.9082, F.S., and shall submit regional planning documents to enable the Department to comply with the following statutory requirements:

C-1.1.2.1 Section 394.4574(3), F.S.;

C-1.1.2.2 Section 394.461(4)(a)-(c), F.S.;

C-1.1.2.3 Section 394.4573, F.S.;

C-1.1.2.4 Section 394.75, F.S.;

C-1.1.2.5 The Long-Range Program Plan for the Department;

C-1.1.2.6 The Annual Business Plan for the Department;

C-1.1.2.7 Regional operational plans to assist in the development and implementation of the Strategic Plan for the Department; and

C-1.1.2.8 Any ad-hoc plans requested by the Department.

C-1.1.3 County Planning

The Managing Entity shall provide assistance to each county specified in **Section B-3.1** to develop a designated receiving system pursuant to s. 394.4573, F.S. and a transportation plan pursuant to s. 394.462, F.S.

C-1.1.4 Federal Planning

The Managing Entity shall collect and provide data and program information to the Department for the completion of Block Grant application, plans, and reports.

C-1.1.5 Resource Development

The Managing Entity shall, where appropriate, develop additional resources by pursuing third-party payments for services, applying for grants, assisting providers in securing local matching funds and

in-kind services, and employing other methods needed to ensure that services are available and accessible.

C-1.1.6 Triennial Needs Assessment

Effective July 1, 2016, the Managing Entity shall conduct a community behavioral health care needs assessment every three years, to be submitted to the Department no later than October 1 of each applicable year. At a minimum, the assessment shall consider:

C-1.1.6.1 The extent to which each designated receiving system within the Managing Entity service location functions as a "no-wrong-door model," as defined by s. 394.4573, F.S.;

C-1.1.6.2 The availability of treatment and recovery services that use recovery-oriented and peer-involved approaches;

C-1.1.6.3 The availability of less-restrictive services; and

C-1.1.6.4 The use of evidence-informed practices.

C-1.1.7 Annual Business Operations Plan

No later than July 31, of each year, the Managing Entity shall submit an annual business operations plan that outlines the operational plan for the present fiscal year. This plan shall be completed using **Template 4 – Managing Entity Annual Business Operations Plan.** The plan shall outline:

C-1.1.7.1 The current system capacity;

C-1.1.7.2 The Managing Entity's strategies for system engagement including:

C-1.1.7.2.1 A plan, or necessary updates to an existing plan, for reintegrating individuals ready for discharge from the State Mental Health Treatment Facilities to a less restrictive level of care;

C-1.1.7.2.2 The Triennial Needs Assessment, or necessary updates thereto, required by **Section C-1.1.6;**

C-1.1.7.2.3 Updates to the Care Coordination Plan required by **Section C-1.1.10;**

C-1.1.7.2.4 Updates to the Quality Assurance Plan required by **Section C-1.1.11;** and

C-1.1.7.2.5 The annual regional Assisted Living Facilities-Limited Mental Health (ALF-LMH) License Annual Plan required by **Section C-1.3.2.4** and **Guidance 8.**

C-1.1.7.3 Summary information on Managing Entity Specific Initiatives; and

C-1.1.7.4 The initial Network Service Provider Monitoring Plan, as required by **Section C-1.3.1.**

C-1.1.8 Enhancement Plan

Effective as of 2017, the Managing Entity shall develop an annual Enhancement Plan for Department approval, due on September 1. The Enhancement Plan shall:

C-1.1.8.1 Identify a minimum of three and a maximum of five priority needs for services in the geographic area;

C-1.1.8.2 Provide a detailed description of the Managing Entity's strategies for enhancing services to address each priority need;

C-1.1.8.3 Include an implementation plan for each strategy which specifies actions steps and identifies responsible parties; delineates specific services to be purchased and the projected cost of those services; projects the number of individuals to be served and estimates the benefits of the services; and

C-1.1.8.4 Be based upon a planning process which includes consumers and their families, community-based care lead agencies, local governments, law enforcement agencies, service providers, community partners and other stakeholders.

C-1.1.9 Within 90 days of execution, the Managing Entity shall submit, a record transition plan to be implemented in the case of contract termination or non-renewal by either party, in accordance with **Guidance 3 – Managing Entity Expiration, Termination and Transition Planning Requirements.**

C-1.1.10 Care Coordination Plan

Within 60 days of execution, the Managing Entity shall submit a Care Coordination Plan for Department approval prior to implementation. The Managing Entity shall update this plan annually as a component of the Managing Entity Annual Business Operation Plan required by **Section C-1.1.7.** The plan shall, at minimum, address the following areas:

C-1.1.10.1 Specify methods that will be used to reduce, manage, and eliminate Waitlists for services;

C-1.1.10.2 Promote increased planning, use, and delivery of services to individuals, including those with co-occurring substance abuse and mental health disorders;

C-1.1.10.3 Promote access to clinically appropriate services by ensuring the use of screening, assessment, and placement tools designed to identify an appropriate level and intensity of care for an individual;

C-1.1.10.3.1 The Care Coordination plan shall promote a system-wide fidelity-based adoption of the American Society of Addiction Medicine (ASAM) criteria by all Network Service Providers delivering substance abuse treatment services. Information on the ASAM criteria is published at https://www.asam.org/resources/the-asam-criteria/about.

C-1.1.10.4 Promote the use of service outcome data to achieve desired outcomes;

C-1.1.10.5 Promote coordination of behavioral health care with primary care;

C-1.1.10.6 Include a methodology to ensure that people are served at the clinically indicated least restrictive level of care and are diverted from higher levels of care when appropriate; and

C-1.1.10.7 Monitor and implement system changes to promote effectiveness.

C-1.1.11 The Managing Entity shall submit a Quality Assurance Plan documenting the process required by **Section C-1.2.7** within 60 days of execution. This plan shall be updated annually as a component of the Managing Entity Annual Business Operations Plan required by **Section C-1.1.7.** This plan shall be approved by the Department prior to implementation.

C-1.1.12 The Department will review the proposed policies, procedures, and plans required to be submitted by the Managing Entity. The Department will respond in writing indicating approval or noting any deficiencies within 30 business days from the date of receipt. Once approved by the Department, the Managing Entity's policies and procedures may be amended provided that they conform to state and federal laws, state rules, and federal regulations.

C-1.1.13 The Managing Entity shall make available and communicate all plans, policies, procedures, and manuals to the Managing Entity staff, Network Service Providers, Individuals Served, and Stakeholders, as applicable.

C-1.2 Administration Function

C-1.2.1 The Managing Entity shall collaborate with and accept input from Stakeholders to administer services and shall operate in a transparent manner, providing public access to information, notice of meetings and opportunities for participation in Managing Entity decision-making.

C-1.2.2 The Managing Entity shall maintain a comprehensive Network that provides an adequate and reasonable array of services in terms of geographic distribution to meet the service needs of individuals without excessive time and travel requirements.

C-1.2.3 The Managing Entity shall ensure the administration of the Network includes the following programmatic standards:

C-1.2.3.1 Guidance 5 – Residential Mental Health Treatment for Children and Adolescents;

C-1.2.3.2 Guidance 6 – Outpatient Forensic Mental Health Services;

C-1.2.3.3 Guidance 7– State Mental Health Treatment Facility Admission and Discharge Processes;

C-1.2.3.4 The Managing Entity shall facilitate Limited Mental Health Assisted Living Facility (LMH-ALF) training pursuant to Rule 58A-5.0191, F.A.C., and the additional guidance in **Guidance 8 – Assisted Living Facilities with Limited Mental Health (ALF-LMH) Licensure** and the recommended forms provided in **Template 5 – ALF-LMH Forms;**

C-1.2.3.5 The Managing Entity shall promote the SSI/SSDI Outreach, Access, and Recovery (SOAR) initiative with appropriate Network Service Providers in conjunction with the Department. Programmatic guidance is provided in **Guidance 9 – Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, and Recovery (SOAR);**

C-1.2.3.6 Guidance 10 – Prevention Services;

C-1.2.3.7 Guidance 11 – Juvenile Incompetent to Proceed (JITP);

C-1.2.3.8 Guidance 12 – Behavioral Health Network (BNet) Guidelines and Requirements and the required forms provided in **Template 6 – Behavioral Health Network Forms;**

C-1.2.3.9 Guidance 13 – Indigent Psychiatric Medication Program, known as the Indigent Drug Program (IDP);

C-1.2.3.10 The Managing Entity shall be responsible for contracting, and providing oversight of the Prevention Partnership Grants, pursuant to s. 397.99, F.S. The Managing Entity shall require that all Network Service Providers receiving PPG funding complete the Evidence-Based Self-Assessment Survey annually and shall comply with the requirements in **Guidance 14 – Prevention Partnership Grants (PPG);**

C-1.2.3.11 Guidance 15 – Projects for Assistance in Transition from Homelessness (PATH);

C-1.2.3.12 Guidance 16 – Florida Assertive Community Treatment (FACT) Handbook; and

C-1.2.3.13 Guidance 33 – HIV Early Intervention Services.

C-1.2.3.14 The Managing Entity must comply with the applicable obligations under 42 U.S.C., ss. 601, et. seq. The Managing Entity agrees that TANF funds shall be expended for TANF participants as outlined in **Guidance 17 – Temporary Assistance for Needy Families (TANF) Funding Guidance.**

C-1.2.3.15 To ensure the implementation and administration of the Family Intensive Treatment (FIT) team model complies with the Department's programmatic standards, the Managing Entity shall require any Network Service Providers providing FIT model services adhere to the staffing, service delivery and reporting requirements of **Guidance 18 – Family Intensive Treatment (FIT) Model Guidelines and Requirements.**

C-1.2.3.16 The Managing Entity shall implement the Transitional Voucher project according to the specifications in **Guidance 29 – Transitional Voucher.**

C-1.2.3.17 **If Exhibit F1** contains funds allocated for the implementation of the Partnerships for Success (PFS) grant awarded to the Department under SAMHSA Grant # 1U79SP021677, the Managing Entity shall comply with the subcontracting requirements established in **Guidance 30 - Partnerships for Success (PFS).**

C-1.2.4 Pursuant to s. 394.9082(3)(c), F.S., the Managing Entity shall provide care coordination activities, as specified in **Guidance 4 – Care Coordination**, designed to improve outcomes among individuals in the following priority populations:

C-1.2.4.1 Persons with a Serious Mental Illness (SMI) awaiting placement in a civil SMHTF or awaiting discharge from a SMHTF back to the community.

C-1.2.4.2 Adults with three (3) or more acute care admissions (CSU, Detoxification, and inpatient) within 180 days.

C-1.2.5 The Managing Entity shall notify the Department within 48 hours of conditions related to Network Service Provider performance that may interrupt the continuity of service delivery or involve media coverage.

C-1.2.6 The Managing Entity shall develop a fraud and abuse prevention protocol within 60 days of execution that complies with all state and federal requirements applicable to this contract. This protocol shall be approved by the Department prior to implementation.

C-1.2.7 Quality Assurance

C-1.2.7.1 The Managing Entity shall implement a quality assurance process to identify and address opportunities for improvement of operations for both Network Service Providers and the Managing Entity. The quality assurance process shall include, but is not limited to:

C-1.2.7.1.1 Periodic external review activities conducted by the Department and the Managing Entity to assure that the agreed upon level of service is achieved and maintained by the Managing Entity and its Network Service Providers; and

C-1.2.7.1.2 Assessing compliance with contract requirements, state and federal law and associated administrative rules, regulations, operating procedures, validating quality improvement systems and findings.

C-1.2.7.2 As applicable, the Managing Entity shall actively participate in the Department's local and statewide processes for quality assurance and quality improvement.

C-1.2.8 The Managing Entity shall be responsible, upon discovery of an incident involving a client whose services are paid for in whole or in part by the Managing Entity, for the management and oversight of incident reporting in accordance with the CFOP 215-6, Incident Reporting and Analysis System (IRAS).

C-1.2.9 The Managing Entity shall cooperate with the Department when investigations are conducted regarding a regulatory complaint relevant to a licensed facility operated by one of the Managing Entity's Network Service Providers.

C-1.2.10 The Managing Entity shall integrate the Department's current initiatives, new state and federal requirements, and policy initiatives into its operations.

C-1.2.11 Coordination with other Providers and Entities

C-1.2.11.1 The Managing Entity shall coordinate with the Community Based Care lead agency, or agencies, as appropriate, to further the child welfare role of the Department, pursuant to s. 409.996(12), F.S and to integrate behavioral health services with the child welfare system. Such coordination shall be in accordance with **Guidance 19 – Integration with Child Welfare**.

C-1.2.11.2 The Managing Entity shall collaborate with and encourage increased coordination between Network Service Providers and the child welfare system, law enforcement agencies, the criminal justice system, the juvenile justice system, the Medicaid program, offices of the public defender, offices of criminal conflict and offices of the civil regional counsel within the geographic area.

C-1.2.11.3 Collaboration with the criminal justice system and the juvenile justice system, including the Department of Juvenile Justice, shall develop strategies and alternatives for diverting individuals from the criminal justice system to the civil system. Such diversion shall apply to persons with mental illness, substance use or co-occurring disorders;

C-1.2.11.4 The Managing Entity shall coordinate with the judicial system to:

C-1.2.11.4.1 Develop specific written procedures and agreements that maximize the use of involuntary outpatient services, reduce involuntary inpatient treatment and increase diversion from the criminal and juvenile justice systems; and

C-1.2.11.4.2 Provide effective and timely services covered through this contract that address the substance abuse and mental health needs of children and parents in the child welfare system and the juvenile justice system.

C-1.2.11.5 The Managing Entity shall participate in the Interagency team meetings created as a result of the Interagency Agreement for child-serving agencies in accordance with **Guidance 20 – Local Review Team.**

C-1.2.11.6 The Managing Entity Shall provide the housing coordination function specified in **Guidance 21 – Housing Coordination**, with Network Service Providers and local housing and homelessness stakeholders, and the Local Community Providers of Services identified at the Department's Office on Homelessness webpage at

http://www.myflfamilies.com/service-programs/homelessness/lead-agencies.

C-1.3 Monitoring Function

C-1.3.1 Within 30 days after execution and annually thereafter the Managing Entity shall submit a Network Service Provider Monitoring Plan for Department approval. The plan shall include:

C-1.3.1.1 A Risk Assessment to develop an annual monitoring schedule.

C-1.3.1.2 A statistically valid sampling methodology to ensure onsite monitoring by the Managing Entity:

C-1.3.1.2.1 At least once every three years, for Network Service Providers with national accreditation,

C-1.3.1.2.2 At least annually for Network Services Providers without national accreditation for which the subcontract includes any level of residential or inpatient services, and

C-1.3.1.2.3 At least biennially for Network Service Providers without national accreditation annually for which the subcontract does not include any level of residential or inpatient services or does not include any client services.

C-1.3.1.3 The monitoring schedule shall distinguish between onsite monitoring and desk reviews.

C-1.3.1.4 Policies, procedures, and tools for General Contract Monitoring, which shall include the following components:

C-1.3.1.4.1 Fiscal stability,

C-1.3.1.4.2 Records,

C-1.3.1.4.3 Corrective Action Plan review,

C-1.3.1.4.4 Audits,

C-1.3.1.4.5 Accounting System,

C-1.3.1.4.6 Insurance,

C-1.3.1.4.7 Sponsorship,

C-1.3.1.4.8 Publicity,

C-1.3.1.4.9 Lobbying,

C-1.3.1.4.10 Client Risk and Incident Reporting,

C-1.3.1.4.11 Intellectual Property Rights,

C-1.3.1.4.12 Data Security,

C-1.3.1.4.13 Confidentiality of Client Information,

C-1.3.1.4.14 Assignments and Subcontracts, and

C-1.3.1.4.15 Grievance Procedures.

C-1.3.1.5 Policies, procedures, and tools for Program Monitoring, which shall include the following components:

C-1.3.1.5.1 Scope of service,

C-1.3.1.5.2 Service tasks,

C-1.3.1.5.3 Staffing requirements,

C-1.3.1.5.4 Deliverables,

C-1.3.1.5.5 Data validation,

C-1.3.1.5.6 Performance specifications,

C-1.3.1.5.7 Network Service Provider responsibilities,

C-1.3.1.5.8 Method of payment, and

C-1.3.1.5.9 Fidelity to evidence-informed level of service need determinations and subsequent service placement.

C-1.3.1.6 Policies, procedures, and tools for Background Screening Monitoring, which shall include the following components:

C-1.3.1.6.1 Level 1 and 2 screening,

C-1.3.1.6.2 Screening exemptions or exclusions, and

C-1.3.1.6.3 Attestations.

C-1.3.1.7 Policies and procedures that comply with s. 394.9082(5)(q), F.S.

C-1.3.1.8 Policies and procedures for corrective action plan closure that ensure validation of all completed corrective action tasks and documentation of improved performance within 90 days after the completion date established in each corrective action plan.

C-1.3.2 The Managing Entity shall monitor Network Service Providers, in compliance with s. 402.7306, F.S., and CFOP 75-8. Monitoring shall include, but is not limited to:

C-1.3.2.1 Compliance with federal and state confidentiality laws;

C-1.3.2.2 Compliance with the requirements and restrictions of the Block Grant funds, and accompanying maintenance of efforts requirements;

C-1.3.2.3 State and federal grant programs;

C-1.3.2.4 Compliance with specific appropriations, or GAA directed projects;

C-1.3.2.5 Compliance with TANF;

C-1.3.2.6 Compliance with the provisions of ch. 65E-14, F.A.C.; and

C-1.3.2.7 A sample of case management records to verify that services identified in community living support plans for residents of Assisted Living Facilities with Limited Mental Health Licenses are provided pursuant to s. 394.4574, F.S.

C-1.3.3 The Managing Entity shall make available to the Department, the results of both planned and ad hoc monitoring, by uploading to the electronic vault within 30 days of completion.

C-1.4 Data Collection, Reporting, and Analysis Function

C-1.4.1 The Managing Entity shall implement shared data systems necessary for the delivery of coordinated care and integrated services, the assessment of Managing Entity performance and Network Service Provider performance and the reporting of outcomes and costs of services.

C-1.4.2 The Managing Entity shall develop and implement policies and procedures that protect and maintain the confidentiality of sensitive information of Individuals Served.

C-1.4.3 The Managing Entity shall require accurate and timely data entry required from Network Service Providers for performance outcomes measurement, in accordance with PAM 155-2, and s. 394.74(3)(e), F.S. The data must:

C-1.4.3.1 Enable expenditures to be tracked by program, fund type, and service;

C-1.4.3.2 Capture service utilization by type and recipient; and

C-1.4.3.3 Document quality of care, access to services, and outcomes for each individual served within the Network.

C-1.4.4 The Managing Entity shall electronically submit all data, as specified in PAM 155-2, to the SAMH Data System by the 18th of each month.

C-1.4.5 The Department will provide a monthly records acceptance and rejection report to the Managing Entity. The Managing Entity shall correct 95% of rejected records within 60 days after each report is issued.

C-1.4.6 Within 60 days of execution, the Managing Entity shall submit an information technology plan for Department approval prior to implementation. This plan shall be reviewed annually for progress. The plan shall demonstrate that the Managing Entity's data system shall be able to meet the following minimum requirements:

C-1.4.6.1 The exchange of screening and assessment results among Network Service Providers to better coordinate care as outlined in the current Information Technology Plan;

C-1.4.6.2 Automated referral and electronic consent for release of confidential information within and between Network Service Providers;

C-1.4.6.3 Integrated processes for tracking and coordinating intake, admission, discharge and follow-up throughout the Network;

C-1.4.6.4 Electronic reconciliation of invoices submitted to the Department, including reconciliation of the amount of funding and services specified in this contract;

C-1.4.6.5 Electronic reconciliation of the Managing Entity's audit report and data information system for Individuals Served;

C-1.4.6.6 Automated processes for state and federal data analysis and reporting; and

C-1.4.6.7 Compliance with federal and state laws, and regulations pertaining to security and privacy of protected health information.

C-1.4.7 The Managing Entity shall provide Department approved Regional and Headquarters staff with access to its data system for Department funded clients and services.

C-1.4.8 The Managing Entity shall provide data system training and training products for Department approved staff.

C-1.4.9 The Managing Entity shall create and maintain accurate and complete Network Service Provider information for its Network in the Data System. The Managing Entity shall require that changes or updates to Network Service Provider records in the SAMH Data System are made within 30 days of a known change.

C-1.4.10 The Managing Entity shall be responsible for maintaining all SAMH Data System access data accounts for persons affiliated with its Network.

C-1.4.11 The Managing Entity shall participate in statewide data activities, including standing Department SAMH data conference calls or meetings. When possible, the Managing Entity shall make arrangements for the Managing Entity data officer or designee to attend policy or strategic meetings in person.

C-1.4.12 The Managing Entity's delegated data officer shall participate in the Department's SAMH data training. The Managing Entity shall be responsible for training other required Managing Entity staff and affiliated personnel on accessing and using SAMH data systems.

C-1.4.13 The Managing Entity shall verify that data submitted is consistent with the data maintained locally by Network Service Providers in their Individuals Served files.

C-1.4.14 The Managing Entity shall review the Department's file upload history in the SAMH Data System to determine the number of records accepted, updated, and rejected. Based on this review,

the Managing Entity shall correct the erroneous records for resubmission in the SAMH Data System within 60 days after submission.

C-1.4.15 The Managing Entity shall require that all data collection required as a result of Federal and State grant awards is submitted to the appropriate parties and completed within the timeframes established by the grantor. The Department will provide technical assistance to the Managing Entity.

C-1.4.16 The Managing Entity shall require public receiving facilities, detoxification facilities and addictions receiving facilities within its Network Service Providers to collect and submit the acute care service utilization data specified in s. 394.9082(10), F.S., according to the timeframes established therein, using a file transfer protocol process or a web portal developed by the Managing Entity.

C-1.5 Fiscal Responsibility Function

C-1.5.1 The Managing Entity shall comply with **Guidance 22 – Federal Grant Financial Management Requirements.**

C-1.5.2 The Managing Entity's financial management and accounting system must have the capability to generate financial reports detailing by fund source, individual recipient utilization, and cost, which, at a minimum, will meet federal requirements for the Block Grants

C-1.5.3 The Managing Entity shall ensure that it budgets and accounts for revenues and expenditures in compliance with Ch. 65E-14, F.A.C.

C-1.5.4 Direct and indirect costs eligible for payment from Department funds are expenses directly incurred by the Managing Entity to manage Behavioral Health Services under and pursuant to this contract and in accordance with:

C-1.5.4.1 2 CFR Part 200 – Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards;

C-1.5.4.2 2 CFR Part 300.1 – Adoption of 2 CFR Part 200;

C-1.5.4.3 45 CFR Part 75 – Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards; and

C-1.5.4.4 The Reference Guide for State Expenditures, which is incorporated herein by reference and may be located at: www.myfloridacfo.com/aadir/reference_guide/

C-1.5.5 Managing Entity operational and indirect costs shall not include any Network Service Provider indirect costs.

C-1.6 Disaster Planning and Response Function

C-1.6.1 Planning

The Managing Entity shall cooperate with the Department to develop a regional disaster plan that reflects the Managing Entity's planned involvement with community-based disaster management agencies. The regional disaster plan shall include, but not be limited to, pre-disaster records protection; alternative suitable accommodations and supplies for Individuals Served in residential settings during a disaster or emergency; and post-disaster recovery efforts which allow for post-disaster continuity of services.

C-1.6.2 Response

The Managing Entity shall be responsible for providing the FEMA CCP services in the event of a qualifying declared major disaster.

C-1.6.2.1 The Managing Entity shall designate a CCP Network Service Provider for each county within the Managing Entity's service area and provide a comprehensive list of

said Network Service Providers to the Department's Disaster Behavioral Health Coordinator within 60 days of execution and within 10 days of any changes to the designated Network Service Provider.

C-1.6.2.2 At the direction of the Department's Disaster Behavioral Health Coordinator, the Managing Entity shall implement CCP services through the designated CCP Network Service Provider according to the terms and conditions of any CCP grant award approved by representatives of FEMA and SAMHSA, using the CCP contract template, provided in **Guidance 23 – Crisis Counseling Program**.

C-1.6.2.3 The Managing Entity shall ensure compliance with the FEMA CCP Guidance, which is incorporated herein by reference and may be located at:

https://www.samhsa.gov/dtac/ccp-toolkit

C-1.7 Additional Region-Specific Tasks

The Managing Entity shall comply with the additional region-specific tasks specified in **Exhibit C1**.

C-2 Administrative Tasks

C-2.1 Staffing

C-2.1.1 The Managing Entity shall comply with their staffing plan contained in the Department-approved SAMH Projected Operating and Capital Budget submitted using Form CF-MH 1042, in accordance with Rule 65E-14.021, F.A.C.

C-2.1.2 The Managing Entity shall, within five business days, submit written notification to the Contract Manager if any of the following positions are to be changed and identify the individual and qualifications of the successor:

C-2.1.2.1 Chief Executive Officer (CEO);

C-2.1.2.2 Chief Operations Officer (COO); or

C-2.1.2.3 Chief Financial Officer (CFO).

C-2.1.3 The structure and membership of Managing Entity's Board of Directors shall comply with s. 394.9082(4), F.S., ch. 617, F.S., and Executive Order 18-81.

C-2.1.4 The Managing Entity shall nominate a member of their staff to perform the following functions:

C-2.1.4.1 A member of the Managing Entity staff that is available to the Department for providing an immediate response 24 hours a day, seven days a week.

C-2.1.4.2 A member of the Managing Entity staff to be a Consumer Affairs Representative, or equivalent title. The name of and contact information for this person shall be submitted to the Department at execution and annually on or before July 1.

C-2.1.4.3 A member of the Managing Entity staff to serve as the Facilities Representative, or equivalent title as point of contact for reintegrating individuals that are ready for discharge from State Mental Health Treatment Facilities. The name and contact information of this person shall be submitted to the Department at execution and updated annually no later than July 1.

C-2.1.4.4 A member of the Managing Entity staff to serve as the Network Service Provider Affairs Ombudsman, or equivalent title. This position shall be the first point of contact for Network-Managing Entity questions, concerns, and disputes. The name and

contact information of this person shall be submitted to the Department at execution and updated annually no later than July 1.

C-2.1.4.5 A member of the Managing Entity or a subcontractor staff to serve as a Data Officer to participate in statewide data activities.

C-2.1.4.6 A member of the Managing Entity staff to serve as a Full-Time Equivalent (FTE) Lead Housing Coordinator, in compliance with the provisions of **Guidance 21 – Housing Coordination**.

C-2.2 Subcontracting

C-2.2.1 The Managing Entity shall subcontract with Network Service Providers to provide community-based Behavioral Health Services, as authorized in ss. 394.74 and 394.9082, F.S., subject to the provisions of **Section 4.3.**

C-2.2.2 Additional Program Specific Funds

C-2.2.2.1 The Managing Entity shall incorporate into subcontracts any additional program-specific funds appropriated by the Legislature for services, as specified in **Exhibit C2.** Any increases will be documented through an amendment to this Contract, resulting in a current fiscal year funding and corresponding service increase. Such increase in services must be supported by additional deliverables as outlined in the amendment.

C-2.2.2.2 Each subcontract with providers or projects identified in **Exhibit C2** as specified by the current fiscal year General Appropriations Act shall contain terms and conditions requiring quarterly Return On Investment (ROI) reporting.

C-2.2.2.2.1 For each applicable subcontract, unless provided a multiple-provider specific reporting template by the Department, the Managing Entity shall negotiate a specific ROI performance measure aligned to the terms of the funding requests filed with the legislature for each provider or project.

C-2.2.2.2.2 The performance measure shall include a specific methodology for calculating the ROI in terms of savings to the state or cost avoidance incurred as a result of the designated funding.

C-2.2.2.2.3 The Managing Entity shall submit a proposed ROI report template for Department approval and shall incorporate the ROI performance measure, the approved reporting template and subcontractor quarterly ROI reporting requirements into the subcontract before August 31 each fiscal year.

C-2.2.2.3 The Managing Entity shall collaborate with the Department to amend into this Contract all applicable requirements of any appropriations, awards, initiatives, or federal grants received by the Department.

C-2.2.3 All subcontracts with Network Service Providers shall include, at a minimum:

C-2.2.3.1 The applicable terms and conditions of this contract;

C-2.2.3.2 Provisions to require compliance with:

C-2.2.3.2.1 Exhibit B1;

C-2.2.3.2.2 2 CFR Part 200 – Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards;

C-2.2.3.2.3 2 CFR Part 300.1 – Adoption of 2 CFR Part 200;

C-2.2.3.2.4 45 CFR Part 75 – Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards

C-2.2.3.2.5 the Reference Guide for State Expenditures;

C-2.2.3.2.6 Chapter 65E-14, F.A.C.;

C-2.2.3.2.7 Block Grant requirements, including maintenance of effort;

C-2.2.3.2.8 State and federal grant requirements;

C-2.2.3.2.9 TANF requirements, if applicable; and

C-2.2.3.2.10 Department policies related to the delivery of service.

C-2.2.3.3 Clearly identifiable deliverables and performance measures that set minimum acceptable levels of service;

C-2.2.3.4 The outcome measures established pursuant to **Section E-2.** The methodology and algorithms to be used in determining performance are outlined in **Guidance 24 – Performance Outcomes Measurement Manual;**

C-2.2.3.5 The National Voter Registration Act (NVRA) of 1993, Pub. L. 103-31 (1993), ss. 97.021 and 97.058, F.S., and ch. 1S-2.048, F.A.C., in accordance with **Guidance 25 – National Voter Registration Act Guidance;**

C-2.2.3.6 Participation in any Department-sponsored Network Service Provider satisfaction surveys; and

C-2.2.3.7 Adoption of the American Society of Addiction Medicine (ASAM) level of care determination criteria for all subcontracts serving persons with substance use disorders. The ASAM criteria are published at https://www.asam.org/resources/the-asam-criteria/about.

C-2.2.4 The Managing Entity shall conduct cost analyses for each subcontract and all supporting documentation shall be retained in the Managing Entity's contract file for the respective Network Service Provider.

C-2.2.5 Subject to the limitations of Florida law, the Managing Entity shall develop a procurement policy that will outline the processes used to publicize opportunities to join the Network and evaluate Network Service Providers for continued participation in the Network. The procurement policy shall be approved by the Department prior to implementation and made publicly available on the Managing Entity's website. This policy shall comply with state and federal expectations for grantees, and the effective use of public funding. This policy shall be submitted within 90 days of execution and must be approved by the Department prior to implementation.

C-2.2.6 The Managing Entity shall make all subcontract documents available in an Electronic Vault. The Managing Entity shall ensure that all documents are clearly legible and those not requiring an original signature are uploaded in their original formats. All contracts initially assigned to the Managing Entity must be uploaded to the Electronic Vault within 60 days of assignment to the Managing Entity. All new contracts or changes to existing contracts shall be uploaded within 10 business days of contract execution.

C-2.2.7 Files of Individuals Served

The Managing Entity shall require that Network Service Providers maintain all current and subsequent medical records and clinical files of Individuals Served. In the event a Network Service Provider program closes, the Managing Entity shall:

C-2.2.7.1 Maintain all inactive records documenting services provided with SAMH funds in compliance with the records retention requirements of **Section 5**; and

C-2.2.7.2 Coordinate the transition of active records documenting services provided with SAMH funds to a successor Network Service Provider for the program, as identified by the Managing Entity, in compliance with any service transition requirements in the terminated subcontract or a transition plan developed in coordination with the successor Network Service Provider.

C-2.2.8 Satisfaction Survey for Individuals Served

The Managing Entity shall ensure all Network Service Providers conduct satisfaction surveys of Individuals Served pursuant to PAM 155-2.

C-2.2.9 Third Party Billing

The Managing Entity shall adhere to the following guidelines for payment of services billed by Network Service Providers:

C-2.2.9.1 Department funds may not reimburse services provided to:

C-2.2.9.1.1 Individuals who have third party insurance coverage when the services provided are paid under the insurance plan; or

C-2.2.9.1.2 Medicaid enrollees or recipients of another publicly funded health benefits assistance program, when the services provided are paid by said program.

C-2.2.9.2 Department funds may reimburse services provided to:

C-2.2.9.2.1 Individuals who have lost coverage through Medicaid, or any other publicly funded health benefits assistance program coverage for any reason during the period of non-coverage; or

C-2.2.9.2.2 Individuals who have a net family income less than 150 percent of the Federal Poverty Income Guidelines, subject to the sliding fee scale requirements in Rule 65E-14.018 F.A.C.

C-2.2.9.3 The Managing Entity shall ensure that Medicaid funds will be accounted for separately from funds for this Contract at both the Network Service Provider and Managing Entity levels. This includes services such as SIPP, FACT, CAT, FIT, and Central Receiving Systems.

C-2.3 Records and Documentation

C-2.3.1 The Managing Entity shall protect the confidentiality of all records in its possession and ensure that all Network Service Providers protect confidential records from disclosure and protect the confidentiality of Individuals Served in accordance with federal and state law.

C-2.3.2 The Managing Entity shall notify the Department of any requests made for public records within 10 business days of receipt of the request and shall assume all financial responsibility for records requests, records storage, and retrieval costs.

C-2.3.3 The Managing Entity shall maintain adequate documentation of the provision of all tasks, deliverables and expenditures related to its operations.

C-2.3.4 The Managing Entity shall monitor the maintenance of Network Service Providers documentation of the provision of all services, sufficient to provide an audit trail.

C-2.4 Reports

C-2.4.1 The Managing Entity shall demonstrate acceptable performance of the administrative functions and progress towards meeting behavioral health service delivery targets by submitting all required documentation specified in **Exhibit C3** by the dates specified therein.

C-2.4.2 The Managing Entity shall make all requested documentation available in the Electronic Vault. All reports and plans or changes to existing reports and plans shall be uploaded within 10 business days of the change or Department approval, when approval of a plan is required.

C-2.4.3 Within 30 days after each fiscal year's **Exhibit F1** is amended into this Contract and prior to the start of a Network Service Provider's contract or subcontract period, the Managing Entity shall:

C-2.4.3.1 Submit a revised Form CF-MH 1042, pursuant to Rule 65E-14.021(5)(d), F.A.C.; and

C-2.4.3.2 Review, approve and submit all Network Service Provider forms required pursuant to Rule 65E-14.021(5)(e), F.A.C., and submit to the Department in the Electronic Vault.

C-2.4.4 The Managing Entity shall require that all Network Service Providers comply with **Attachment 3.**

C-2.4.5 Local Match

The Managing Entity shall ensure that Network Service Providers annually complete and submit the Department-approved **Template 9 – Local Match Calculation Form.**

C-2.4.6 Quarterly Report

The Managing Entity shall submit a report detailing its quarterly activities and performance, no later than October 20, January 20, April 20 and August 15. The report shall contain the following minimum elements:

C-2.4.6.1 Exhibit B1;

C-2.4.6.2 Overview of necessary adjustments to any elements of the Annual Business Operation Plan required by **Section C-1.1.7**, including justification for proposed changes, identification of barriers or anticipated barriers to achieving stated goals, and proposed strategies to mitigate the impact of said barriers on the Network;

C-2.4.6.3 Network management including:

C-2.4.6.3.1 New subcontracts, or amendments to existing subcontracts with Network Service Providers;

C-2.4.6.3.2 Collaborative strategies and activities with the Department or Stakeholders; and

C-2.4.6.3.3 Adverse fiscal impact of proposed Network changes and recommendations for resolution.

C-2.4.6.4 Network Service Provider performance including:

C-2.4.6.4.1 Monitoring and review results, including reports and corrective action plans or other necessary follow-up actions; and

C-2.4.6.4.2 Performance measures.

C-2.4.6.5 Implementation of specific appropriations, or grant funds; , including copies of all ROI reports required by **Section C-2.2.2.2**;

C-2.4.6.6 Any adverse finding or report against a Network Service Provider by any regulatory or law enforcement entity; and

C-2.4.6.7 Any additional recurring reporting elements requested by the Department.

C-2.4.7 Where this Contract requires the delivery of reports to the Department, mere receipt by the Department shall not be construed to mean or imply acceptance of those reports. It is specifically intended by the parties that acceptance of required reports shall require a separate act in writing within 15 days of receipt of the report by the Department. The Department reserves the right to reject reports as incomplete, inadequate, or unacceptable according to the parameters set forth in this contract and must notice the Managing Entity electronically within 15 days of receipt of the report by the Department. The Department may allow additional time within which the Managing Entity may remedy the objections noted by the Department or the Department may, after having given the Managing Entity a reasonable opportunity to complete, make adequate, or acceptable, such reports, declare the contract to be in default.

C-2.5 Preference to Florida-Based Businesses

The Managing Entity shall maximize the use of state residents, state products, and other Florida-based businesses in fulfilling its contractual duties under this contract.

C-2.6 Use of Department's Operating Procedures

The Managing Entity shall use the Department's Operating Procedures until its agency procedures are approved by the Department for implementation. In the event of differing interpretation, the parties agree to meet for resolution. The Managing Entity shall have its operating procedures approved within 180 days of contract execution. The Department agrees to review proposed operating procedures submitted by the Managing Entity and will respond in writing with comments or will approve within 30 working days from the day of receipt. Once approved by the Department, the Managing Entity's operating procedures may be amended without further Departmental review provided that they conform to state and federal laws and regulations.

C-2.7 National Provider Identifier (NPI)

C-2.7.1 All health care providers, including Managing Entities and Network Service Providers, are eligible to be assigned a Health Insurance Portability and Accountability Act (HIPAA) National Provider Identifier (NPI). However, health care providers who are covered entities (which includes all state-contracted community SAMH providers and State Treatment Facilities) must obtain and use NPIs.

C-2.7.2 An application for an NPI may be submitted online at:

https://hmsa.com/portal/provider/zav_pel.ph.NAT.500.htm

C-2.7.3 Additional information can be obtained from one of the following websites:

C-2.7.3.1 The Florida Medicaid Health Insurance Portability and Accountability Act:

http://www.fdhc.state.fl.us/medicaid/hipaa

C-2.7.3.2 The National Plan and Provider Enumeration System (NPPES):

https://nppes.cms.hhs.gov/NPPES/Welcome.do

C-2.7.3.3 The CMS NPI:

https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/

C-3 Standard Contract Requirements

The Provider will perform all acts required by **Sections 4, 5, 7, 8 and 9** of this Contract.

EXHIBIT C1 – ADDITIONAL REGION-SPECIFIC TASKS

C1-1 Southeast Region Specific Performance Metrics

The Managing Entity will assist in developing performance metrics as determined by the Department's Regional leadership to support Southeast Region Priorities. These metrics and outcomes will be reported by the ME to the Department's Regional Staff as requested.

C1-2 Collaboration with Southeast Region Assignments

The Managing Entity will work in collaboration with the Southeast Region SAMH staff in completing, according to given deadlines, any assignments given to the Southeast Region, which involve the ME and/or its subcontractors and for which the ME would have or have access to the needed information.

C1-3 Communications

C1-3.1 Reports

C1-3.1.1 The Managing Entity will submit all required reports (Including Monthly Performance Report) directly (via email or postal service) to the Contract Manager.

C1-3.1.2 All communications from the Managing Entity to the Department must include the Contract Manager and the Regional SAMH Director.

C1-3.1.3 All Public Meetings as well as Board and Board Committee Meetings must be noticed directly to the Contract Manager and the Regional SAMH Director.

C1-3.2 Partnership Meetings

The Managing Entity and the Southeast Region SAMH Office will meet at a minimum of every two months regarding programmatic issues and updates in the SAMH System of Care for the Region.

C1-3.3 Client, Stakeholder and/or Provider Issues, Incidents, Complaints

When a client, stakeholder, or Provider Issue rises to the level where further investigation or intervention appears warranted, the Managing Entity will:

C1-3.3.1 Share currently available Information about the issue with the SER SAMH designated staff;

C1-3.3.2 Coordinate with the SER staff how the ME will proceed;

C1-3.3.3 Review findings of the process and outcome(s) with the SER SAMH staff.

C1-4 Regionally Necessary Services

C1-5.1 The terms of Section B-3.1 notwithstanding, the Managing Entity will discuss with the Department prior to utilizing services outside Broward County, with such services being considered on a case-by-case basis and with simultaneous concerted efforts conducted by the Managing Entity to develop such services locally.

EXHIBIT C2 – REGION-SPECIFIC APPROPRIATIONS

C2-1 Pursuant to the terms of **Section C-2.2.2.1**, the Managing Entity shall subcontract for the for the Department-specified special projects and the legislatively appropriated program-specific funds detailed herein. Each subcontract shall require the Network Service Provider to use these funds only for the specified service and to report the unique numbers of persons served or services provided with these funds as distinct reporting elements within the subcontract report requirements.

C2-2 The Managing Entity shall provide the Department with a copy of the executed subcontract document for each program-specific fund no later than 30 days after this exhibit is incorporated into the Managing Entity's contract. The subcontract document shall include:

C2-2.1 A description of the service purchased with the specific appropriation;

C2-2.2 The payment methodology and rate applied to the service;

C2-2.3 Output and outcome performance measures applied to the service; and

C2-2.4 The reporting requirements implemented to ensure regular and ad hoc status updates to the Department.

C2-3 The Managing Entity shall ensure each Network Service Provider:

C2-3.1 Complies with all applicable reporting standards established for the special project or service identified herein, and

C2-3.2 Complies with any requirements established by the Executive Office of the Governor for return on investment reporting.

C2-4 Department-Specified Special Projects

C2-4.1 Prevention Partnership Grants

Pursuant to Notices of Award for the PPG procurement, the Managing Entity shall execute 3-year subcontracts with Network Service Providers for the amounts detailed in **Table 1a** for the implementation of the PPG program.

C2-4.1.1 Beginning Fiscal Year 2015-16, the Managing Entity shall execute subcontract based on the Notice of Award for RFA # LHZ03.

C2-4.1.2 Beginning Fiscal Year 2018-19, the Managing Entity shall execute subcontracts based on the Notice of Award for RFA # 10H17GN1.

C2-4.1.3 The Managing Entity shall negotiate PPG services within the scope of work detailed in the Network Service Provider's application.

C2-4.1.4 The Subcontract shall incorporate the specifications and elements detailed in the RFA, including but not limited to objectives, measures, and reporting.

C2-4.1.5 The Subcontract shall incorporate funding as detailed in **Table 1a** for reasonable, allowable, and necessary expenditures required to perform PPG services.

C2-4.1.6 The Subcontract shall require the Network Service Provider to enter all prevention data into the Department's Performance Based Prevention System (PBPS).

C2-4.2 Central Receiving Systems

C2-4.2.1 The Managing Entity shall execute 5-year subcontracts with Network Service Providers for the amounts detailed in **Table 1a**, pursuant to the Notice of Award for the CRS solicitation under RFA # RFA07H16GS2 and Specific Appropriation 386K of the FY16-17 General Appropriations Act.

C2-4.2.2 The Managing Entity shall implement the CRS projects in accordance with the terms of **Guidance 27 – Centralized Receiving System (CRS) Grant.**

C2-4.3 FEMA DR 4337 FL - Hurricane Irma Disaster Behavioral Health Response

In response to the impact of Hurricane Irma, the Managing Entity shall implement the FEMA Crisis Counseling Program (CCP) Immediate Services Program (ISP), as defined in **Guidance 23**, under the project name "Project H.O.P.E. (Helping Our People in Emergencies)." The Managing Entity shall subcontract for these services as specified in **Section C-1.7.2** and shall comply with the provisions regarding supplemental method of payment in **Section F-8.**

C2-4.3.1 The Managing Entity shall implement the program in Broward County.

C2-4.3.2 The Managing Entity shall implement the program in compliance with the terms of the DR 4337 FL Notice of Award, and with the plan of services and budget narratives contained in Department's ISP Application, which are hereby incorporated by reference. Copies of the Notice of Award and the ISP Application are maintained in the contract file.

C2-4.4 Marjory Stoneman Douglas High School Public Safety Act

C2-4.4.1 Pursuant to Ch. 2018-03, Laws of Florida, Section 48, the Managing Entity shall conduct a procurement to establish additional Mobile Crisis Teams in the Managing Entity's service region. The procurement must:

C2-4.4.1.1 Be conducted with the collaboration of local Sheriff's Offices in the procurement planning, development, evaluation, and selection process;

C2-4.4.1.2 Be designed to ensure reasonable access to services among all counties in the Managing Entity's service region, taking into consideration the geographic location of existing mobile crisis teams;

C2-4.4.1.3 Require services be available 24 hours per day, seven days per week with on-site response time to the location of referred crises within 60 minutes of the request for services;

C2-4.4.1.4 Require the Network Service Provider to establish formalized written agreements to establish response protocols with local law enforcement agencies and local school districts or superintendents;

C2-4.4.1.5 Require access to a board-certified or board-eligible Psychiatrist or Psychiatric Nurse Practitioner;

C2-4.4.1.6 Provide for an array of crisis response services that are responsive to the individual and family needs, including screening, standardized assessments, early identification, or linkage

C2-4.4.2 The Managing Entity shall conduct the procurement required herein using a competitive solicitation consistent with the competitive solicitation procedures contained within the Managing Entity's Department-approved procurement policies. In addition to those procedures, the Managing Entity shall:

C2-4.4.2.1 Advertise the solicitation on a public-facing website and, on the day the solicitation is advertised, provide a link to the solicitation to the Department for additional distribution and publication;

C2-4.4.2.2 Conduct a public meeting for the solicitation evaluation on the same terms as a public meeting as defined in s. 286.011, F.S.; and

C2-4.4.2.3 Document completion of the solicitation through the publication of a Notice of Intent to Award on a public-facing website no later than October 31, 2018.

C2-5 Fiscal Year 2014-15 Appropriation

Pursuant to the FY14-15 General Appropriations Act, Ch. 2014-51, Laws of Fla., the Managing Entity shall implement the following summarized in **Table 1b**:

C2-5.1 Specific Appropriation 3772 – Pregnant Women, Mothers, and Affected Families Funding

From Specific Appropriation 372, recurring General Revenue for the expansion of substance abuse services for pregnant women and their affected families. These services shall include the expansion of residential treatment, outpatient treatment with housing support, outreach, detoxification, child care and post-partum case management supporting both the mother and child consistent with recommendations from the Statewide Task Force on Prescription Drug Abuse and Newborns. Priority for services shall be given to counties with greatest need and available treatment capacity.

C2-6 Fiscal Year 2015-16 Appropriations

Pursuant to the FY15-16 General Appropriations Act, Ch. 2015-232, Laws of Fla., the Managing Entity shall implement the following projects, summarized in **Table 1c**:

C2-6.1 Specific Appropriation 377J – Pregnant Women, Mothers, and Affected Families Funding

C2-6.1.1 From the funds in Specific Appropriation 377J, recurring General Revenue for the expansion of substance abuse services for pregnant women and their affected families. These services shall include the expansion of residential treatment, outpatient treatment with housing support, outreach, detoxification, child care and post-partum case management supporting both the mother and child consistent with recommendations from the Statewide Task Force on Prescription Drug Abuse and Newborns. Priority for services shall be given to counties with greatest need and available treatment capacity.

C2-6.1.2 The Managing Entity shall subcontract with the Network Service Providers for this funding as listed in Table 1a. These subcontracts shall be executed and managed in accordance with **Guidance 26 – Women's Special Funding.** With the submission of the Final Fiscal Year Invoice, the Managing Entity will submit a report that details for each provider the sub contractual amount, actual amount paid, and total units purchased. This report shall also contain the total of any anticipated carry forward funds of Specific Appropriation 377J – Pregnant and Post-Partum Women Funding. These anticipated carry forward funds will also be included on **Template 13.**

C2-6.2 Specific Appropriation 377J – Family Intensive Treatment Funding

C2-6.2.1 From the funds in Specific Appropriation 377J, General Revenue to implement the Family Intensive Treatment (FIT) team model that is designed to provide intensive team-based, family-focused, comprehensive services to families in the child welfare system with parental substance abuse. Treatment shall be available and provided in accordance with the indicated level of care required and providers shall meet program specifications. Funds shall be targeted to select communities with high rates of child abuse cases located in the Department of Children and Families' Central, Northeast, Southern, and SunCoast regions.

C2-6.2.2 The Family Intensive Treatment (FIT) team model is designed to provide intensive team-based, family-focused, comprehensive services to families in the child welfare system with parental substance abuse. Treatment shall be available and provided in accordance with the indicated level of care required and providers shall meet program specifications. Funds shall be targeted to select communities with high rates of child abuse cases.

C2-6.2.3 The Managing Entity shall initiate a competitive bid process to deliver the FIT model by July 31, 2015.

C2-6.2.4 The Managing Entity shall subcontract with Network Service Providers on or before October 1, 2015, to provide FIT model services for the full amount of funding specified in Table 1a and shall not reduce payment to these providers for any operational costs, including behavioral health fees, of the Managing Entity associated with the administration of the subcontracts.

C2-7 Fiscal Year 2016-17 Appropriations

Pursuant to the FY16-17 General Appropriations Act, Ch. 2016-66, Laws of Fla., the Managing Entity shall implement the following, summarized in **Table 1d**:

C2-7.1 Specific Appropriation 383 – Forensic Multidisciplinary Team (FMDT)

From the funds in Specific Appropriation 383, recurring General Revenue Fund is provided for the creation of a pilot community Forensic Multidisciplinary Team designed to divert individuals from secure forensic commitment by providing community-based services. To implement this pilot proviso project, the Managing Entity shall subcontract with a qualified Network Service Provider in the location specified in **Table 1d** to provide services according to the provisions of **Guidance 28 – Forensic Multidisciplinary Team.**

C2-7.2 Specific Appropriation 385 – Women's Special Funding

From the funds in Specific Appropriation 385, General Revenue for the expansion of substance abuse services for pregnant women, mothers, and their affected families. These subcontracts shall be executed and managed in accordance with **Guidance 26 – Women's Special Funding**. These services shall include the expansion of residential treatment, outpatient treatment with housing support, outreach, detoxification, child care and post-partum case management supporting both the mother and child consistent with recommendations from the Statewide Task Force on Prescription Drug Abuse and Newborns. Priority for services shall be given to counties with the greatest need and available treatment capacity.

C2-7.3 Specific Appropriation 385 – Family Intensive Treatment Funding

From the funds in Specific Appropriation 385, General Revenue to implement the Family Intensive Treatment (FIT) team model that is designed to provide intensive team-based, family-focused, comprehensive services to families in the child welfare system with parental substance abuse. These subcontracts shall be executed and managed in accordance with **Guidance 18 – Family Intensive Treatment (FIT) Model Guidelines and Requirements.** Treatment shall be available and provided in accordance with the indicated level of care required and providers shall meet program specifications. Funds shall be targeted to select communities with high rates of child abuse cases.

C2-8 Fiscal Year 2017-18 Appropriations

Pursuant to the FY17-18 General Appropriations Act, Ch. 2017-70, Laws of Fla., the Managing Entity shall implement the following, summarized in **Table 1e**:

C2-8.1 Specific Appropriation 361A Projects

C2-8.1.1 Community Action Treatment (CAT) Team

From the funds in Specific Appropriation 361A, General Revenue to implement the Community Action Treatment (CAT) Team a multidisciplinary treatment team that provides services to children and young adults with a history of mental illness, multiple treatment failures, and who are at risk of out of home placement or return to out of home placement. The Managing Entity will conduct activities in accordance with the terms of **Guidance 32 - Community Action Treatment (CAT) Team.**

C2-8.2 Additional FIT Team Services

From the funds in Specific Appropriation 361A, General Revenue to implement additional FIT Team services as specified in **Section C2-8.4.**

C2-8.3 Specific Appropriation 364 – Recurring – Henderson Behavioral Health Transitional Beds

From the funds in Specific Appropriation 364, the following recurring base appropriations projects shall be funded with general revenue funds: Henderson Behavioral Health - Forensic treatment services ..... 1,163,520 (FY17-18 partial year allocation)

C2-8.3.1 This project is a continuation of Contract LH287 as assigned to the Managing Entity, effective 9/1/17.

C2-8.3.2 This project implements the following appropriation from the FY16-17 General Appropriations Act and, subject to continual appropriation, will be funded at $1,401,600 for future fiscal years.

... the General Revenue Fund is provided for an expansion of forensic mental health transitional beds to divert individuals sentenced under chapter 916, Florida Statutes, from the county jail system and to move eligible individuals currently in forensic state mental health institutions to community settings as an alternative to more costly institutional placement.

C2-8.4 Specific Appropriation 366 Projects

C2-8.4.1 Women's Special Funding

From the funds in Specific Appropriation 366, General Revenue for the expansion of substance abuse services for pregnant women, mothers, and their affected families. These subcontracts shall be executed and managed in accordance with **Guidance 26 – Women's Special Funding.** These services shall include the expansion of residential treatment, outpatient treatment with housing support, outreach, detoxification, child care and post-partum case management supporting both the mother and child consistent with recommendations from the Statewide Task Force on Prescription Drug Abuse and Newborns. Priority for services shall be given to counties with the greatest need and available treatment capacity.

C2-8.4.2 Family Intensive Treatment Funding

From the funds in Specific Appropriation 366, General Revenue to implement the Family Intensive Treatment (FIT) team model that is designed to provide intensive team-based, family-focused, comprehensive services to families in the child welfare system with parental substance abuse. These subcontracts shall be executed and managed in accordance with **Guidance 18 – Family Intensive Treatment (FIT) Model Guidelines and Requirements**. Treatment shall be available and provided in accordance with the indicated level of care required and providers shall meet program specifications. Funds shall be targeted to select communities with high rates of child abuse cases.

C2-8.5 Specific Appropriation 369 Project – Memorial General Hospital

From the funds in Specific Appropriation 369, the nonrecurring sum of $500,000 from the Welfare Transition Trust Fund is provided for the Maternal Addiction Treatment Program at Memorial Regional Hospital in Broward County (HB 3677).

C2-9 Fiscal Year 2018-19 Appropriations

Pursuant to the FY18-19 General Appropriations Act, Ch. 2018-10, Laws of Fla., the Managing Entity shall implement the following, summarized in **Table 1f**:

C2-9.1 Specific Appropriation 366 Project - Community Action Treatment (CAT) Team

C2-9.1.1 From the funds in Specific Appropriation 366, recurring general revenue funds shall be competitively procured by the department for Community Action Treatment Team services.

C2-9.1.2 Pursuant to the Managing Entity's FY2017-18 procurement, the Managing Entity shall subcontract with Smith Community Mental Health to provide CAT team services per the terms of **Guidance 32** in Broward County.

C2-9.2 Specific Appropriation 367 Project – Henderson Behavioral Health Transitional Beds

C2-9.2.1 From the funds in Specific Appropriation 367, the following recurring base appropriations projects shall be funded with general revenue funds:

Henderson Behavioral Health - Forensic treatment services... 1,401,600

C2-9.2.2 This project is a continuation of Contract LH287 as assigned to the Managing Entity, effective 9/1/17.

C2-9.3 Specific Appropriation 369 Projects

C2-9.3.1 Women's Special Funding

From the funds in Specific Appropriation 369, recurring General Revenue continues to be provided for the expansion of substance abuse services for pregnant women, mothers, and their affected families. These subcontracts shall be executed and managed in accordance with **Guidance 26** and shall include the expansion of residential treatment, outpatient treatment with housing support, outreach, detoxification, child care and post-partum case management supporting both the mother and child consistent with recommendations from the Statewide Task Force on Prescription Drug Abuse and Newborns.

C2-9.3.2 Family Intensive Treatment Funding

From the funds in Specific Appropriation 369, recurring sums from the General Revenue Fund and from the Alcohol, Drug Abuse and Mental Health Trust Fund are provided to implement the Family Intensive Treatment (FIT) team model. The Managing Entity shall execute and manage subcontracts for these services in accordance with **Guidance 18.**

C2-9.4 Specific Appropriation 372 Projects

From the funds in Specific Appropriation 372, the following project is funded with nonrecurring general revenue funds: Memorial Healthcare - Medication Assisted Treatment Program (HB 3411) (Senate Form 1327) ... 500,000

C2-10 Fiscal Year 2019-20 Appropriations

Pursuant to the FY19-20 General Appropriations Act, Ch. 2019-115, Laws of Fla., the Managing Entity shall implement the following, summarized in **Table 1g**:

C2-10.1 Specific Appropriation 367 Project

Funds provided in Specific Appropriation 367 shall be used to subcontract for the operation of Community Action Treatment (CAT) teams, per the terms of **Guidance 32.** The following recurring base appropriation project is funded from general revenue funds: Smith Community Mental Health - Broward.

C2-10.2 Specific Appropriation 368 Project

From the funds in Specific Appropriation 368, the following recurring base appropriations project is funded with general revenue funds: Henderson Behavioral Health - Forensic treatment services... 1,401,600

C2-10.3 Specific Appropriation 370 Projects

C2-10.3.1 Women's Special Funding

From the funds in Specific Appropriation 370, General Revenue shall continue to be provided for the expansion of substance abuse services for pregnant women, mothers, and their affected families. These subcontracts shall be executed and managed in accordance with **Guidance 26** and shall include the expansion of residential treatment, outpatient treatment with housing support, outreach, detoxification, child care and post-partum case management supporting both the mother and child consistent with recommendations from the Statewide Task Force on Prescription Drug Abuse and Newborns.

C2-10.3.2 Family Intensive Treatment Funding

From the funds in Specific Appropriation 370, General Revenue is provided to implement the Family Intensive Treatment (FIT) team model. The Managing Entity shall execute and manage subcontracts for these services in accordance with **Guidance 18.**

C2-10.4 Specific Appropriation 373 Projects

From the funds in Specific Appropriation 373, the following project is funded from nonrecurring funds from the Federal Grants Trust Fund using federal funds received from the State Opioid Response Grant: Memorial Healthcare - Medication Assisted Treatment Population Health Program (Senate Form 1639) (HB 4469) ... 1,000,000

Table 1a – Department-Specified Special Projects

Project	Provider		Amount	Recurring?
PPG Solicitation RFA LHZ03	Hanley Center Foundation, Inc		$147,256.00	Yes FY15-16 through FY17-18
PPG Solicitation RFA 0H17GN1	Hanley Center Foundation, Inc		$147,256.00	Yes FY18-19 through FY20-21
CRS Solicitation RFA 07H16GS2	Henderson Behavioral Health, Inc. Effective 1/1/17 through 12/31/22	FY16-17	$2,086,415.00	Yes FY16-17 through FY20-21
		FY17-18	$2,606,185.00	
		FY18-19 to FY20-21	$4,305,021.00	
		FY21-22	$2,272,642.00	
FEMA DR 4337 FL	Hurricane Irma Disaster Behavioral Health Response FEMA CCP Immediate Response Program		$161,671.40	No
Ch. 2018-03, Laws of Florida, Section 48	Mobile Crisis Teams		$118,236.00	Yes

Table 1b – Fiscal Year 2014-15 Appropriations

Appropriation	Provider	Amount	Recurring?
372	Pregnant and Post-Partum Women Funding Allocated to the following providers and amounts 1. Broward Addiction and Recovery Center (BARC) 2. House of Hope 3. Susan B. Anthony Center, Inc. 4. The Starting Place, Inc.	$1,043,188.00	Yes

Table 1c – Fiscal Year 2015-16 Appropriations			
Appropriation	Provider	Amount	Recurring?
377J	Pregnant Women, Mothers, and Affected Families Funding Allocated to the following providers 1. Broward Addiction and Recovery Center (BARC) 2. House of Hope 3. Susan B. Anthony Center, Inc. 4. Banyan Community Health Center, Inc.	$1,043,188.00	Yes
	Family Intensive Treatment (FIT) funding, allocated to the following amounts for services in the designated locations. The Managing Entity shall designate a service provider for each location in accordance with **Section C2-7.2.** Broward County	$600,000.00	Yes

Table 1d – Fiscal Year 2016-17 Appropriations			
Appropriation	Provider	Amount	Recurring?
383	Community Forensic Multidisciplinary Team (FMDT) Broward County – Henderson Behavioral Health, Inc.	$652,000.00	Yes
385	Pregnant Women, Mothers, and Affected Families Funding Allocated to the following providers 1. Broward Addiction and Recovery Center (BARC) 2. House of Hope 3. Susan B. Anthony Center, Inc	$1,043,188.00	Yes
	Family Intensive Treatment (FIT) funding, allocated to the following amounts for services in the designated locations. The Managing Entity shall designate a service provider for each location in accordance with **Section C2-7.2.** Broward County	$600,000.00	Yes

Table 1e – Fiscal Year 2017-18 Appropriations			
Appropriation	Provider	Amount	Recurring?
361A	Community Action Team (CAT) Team funding allocated to Broward County	$750,000.00	Yes
	Additional Family Intensive Treatment (FIT) funding for services in Broward County	$200,000.00	Yes
364	Recurring Henderson Behavioral Health, Inc.– Forensic Transitional Beds	$1,163,520.00	Yes
366	Pregnant Women, Mothers, and Affected Families Funding Allocated to the following providers: 1. Broward Addiction and Recovery Center (BARC) 2. Banyan Community Health Center, Inc. 3. Susan B. Anthony Center, Inc.	$1,043,188.00	Yes
	Family Intensive Treatment (FIT) funding for services in Broward County	$600,000.00	Yes
369	Memorial Regional Hospital	$500,000.00	No

Table 1f – Fiscal Year 2018-19 Appropriations			
Appropriation	Provider	Amount	Recurring?
366	Community Action Team (CAT) Team funding allocated to Smith Community Mental Health - Broward	$750,000.00	Yes
367	Henderson Behavioral Health, Inc.– Forensic Transitional Beds	$1,401,600.00	Yes
369	Pregnant Women, Mothers, and Affected Families Funding Allocated to the following providers: 1. Broward Addiction and Recovery Center (BARC) 2. Banyan Community Health Center, Inc. 3. Susan B. Anthony Center, Inc.	$1,043,188.00	Yes
	Family Intensive Treatment (FIT) funding, allocated to Henderson Behavioral Health for services in Broward County	$800,000.00	Yes
372	South Broward Hospital District, d/b/a Memorial Healthcare System	$500,000.00	No

Table 1g – Fiscal Year 2019-20 Appropriations			
Appropriation	Provider	Amount	Recurring?
367	Community Action Team (CAT) Team funding allocated to Smith Community Mental Health - Broward	$750,000.00	Yes
368	Henderson Behavioral Health, Inc.– Forensic Transitional Beds	$1,401,600.00	Yes

Table 1g – Fiscal Year 2019-20 Appropriations			
Appropriation	Provider	Amount	Recurring?
370	Pregnant Women, Mothers, and Affected Families Funding Allocated to the following providers: 1. Broward Addiction and Recovery Center (BARC) 2. Banyan Community Health Center, Inc. 3. Village South, Inc.	$1,043,188.00	Yes
	Family Intensive Treatment (FIT) funding, allocated to Henderson Behavioral Health	$800,000.00	Yes
373	Memorial Healthcare - Medication Assisted Treatment Population Health Program (Senate Form 1639) (HB 4469)	$1,000,000.00	No

EXHIBIT C3 – ME REQUIRED REPORTS, PLANS, AND FUNCTIONAL TASKS

All Requirements in **Table 2** must be submitted to the Contract Manager electronically and be uploaded to the ME's secure web-based document vault.

Table 2 – Required Submissions

Section	Requirement	Required by	Frequency	Due No Later Than:
C3-1	**Recurring Required Reports and Plans**			
Provider Tangible Property Inventory - *Template 1*		Section B-7.2; Guidance 2	Initial; Annual	Initial: within 30 days of execution; Annual: July 31
Regional planning documents		Section C-1.1.2	As Needed	As Needed
Triennial Needs Assessment		Section C-1.1.6	Every 3 years	October 1, 2019, 2022
Managing Entity Annual Business Operations Plan *Template 4, including:* • *Updates to SMHTF Discharge Reintegration Plan* • *Updates to Triennial Needs Assessment* • *Updates to Care Coordination Plan* • *Updates to Quality Assurance Plan* • *Annual ALF-LMH Plan* • *Annual Network Service Provider Monitoring Plan*		Section C-1.1.7	Annually	July 31
Enhancement Plan		Section C-1.1.8	Annually, beginning 2017	September 1
Record Transition Plan - *Guidance 3*		Section C-1.1.9	Once	Within 90 days of execution
Care Coordination Plan		Section C-1.1.10	Initial	Within 60 days of execution
Quality Assurance Plan		Section C-1.1.11	Initial	Within 60 days of execution
Fraud and Abuse Prevention Protocol		Section C-1.2.6	Once	Within 60 days of execution
Network Service Provider Monitoring Plan		Section C-1.3.1	Initial	Within 30 days of execution
Information Technology Plan		Section C-1.4.6	Once	Within 60 days of execution
Procurement Policy		Section C-2.2.5	Once	Within 90 days of execution
Conditional Release Report -*Template 22*		Guidance 6	Monthly	15th of each month
Forensic Diversion Report - *Template 23*				
Regional Action Steps to Forensic Goals - *Template 26*				
National Voters Registration Act Quarterly Report		Guidance 25	Quarterly	January 10; April 10; July 10; October 10
Forensic Multidisciplinary Team Report - *Template 25*		Guidance 28	Monthly	15th of each month

Table 2 – Required Submissions				
Section	**Requirement**	**Required by**	**Frequency**	**Due No Later Than:**
C3-2	**Required Financial Forms and Documents**			
	Managing Entity Operating and Capital Budget *Template: Form CF-MH 1042, per ch. 65E-14, F.A.C.*	Section C-2.4.3	As Needed	30 days after any amendment to Exhibit F1
	Managing Entity Fixed Advance Payment Invoice - *Template 10*	Sections F-2.2 and F-3.1.1	Annually	July 1
	Interest remittance and documentation of interest on advances	Section F-2.3	Quarterly	As Needed
	Managing Entity Monthly Fixed Payment Invoice - *Template 10*	Section F-3.1.1	Monthly; and FY Final: Annually	20th of month following service delivery FY Final: August 15
	SAMH Managing Entity Monthly Progress Report - *Template 11*	Sections F-3.1.2 and F-3.3		
	SAMH Managing Entity Monthly Expenditure Report – *Template 12*	Section F-3.1.3	Monthly	20th of month following service delivery; FY Final: August 15
	SAMH Managing Entity Monthly Carry Forward Expenditure Report - *Template 13*	Section F-3.1.4		
	Cost Allocation Plan - *Template 14*	Section F-4	Initial, Annual Update, and Revisions as needed	Initial: Within 30 days of execution; Annual Update: August 31; Revisions: Within 20 days of notifying the Department
	Managing Entity Spending Plan for Carry Forward Report *Template 15*	Section F-5.2	Annually	Within 30 days of confirmation of approved amount from the Department
	Financial and Compliance Audit	Attachment 1	Annually, and As needed	The earlier of: 180 days after the end of the provider's fiscal year or 30 days after the ME's receipt of the audit report
	BNet Statement of Program Cost	Guidance 12	Annually	September 1
C3-3	**Required Data Submission and Performance Reporting**			
	Substance Abuse and Mental Health Block Grant Report - *Template 2*	Section B1-4.2	Semi-annually	March 15 September 1
	Narrative Report for the SAMH Block Grant - *Template 3*	Section B1-4.3	Biennially	May 30 of odd-numbered years
	Monthly Data Submission to SAMH Data System	Section C-1.4.4	Monthly	18th of each month
	Submission of Corrected Records to SAMH Data System	Section C-1.4.14	As needed	Within 60 days after initial record submission
	Data required by Federal or State Grant Awards *Other than Sections C3-3.7 and C3-3.8, below*	Section C-1.4.15	As needed	As established by Grantor timeframes
	Quarterly Report	Section C-2.4.6	Quarterly	October 20; January 20; April 20; August 15
	Family Intensive Treatment (FIT) Report - *Template 17*	Guidance 18	Monthly	18th of each month

Table 2 – Required Submissions			
Section / Requirement	**Required by**	**Frequency**	**Due No Later Than:**
Women's Special Funding Data Reporting	Guidance 26	Monthly	18th of each month
Transitional Voucher Incidental Summary	Guidance 29	Quarterly	20th of the month after each quarter
Monthly Care Coordination Report - *Template 21*	Guidance 4	Monthly	20th of month following service delivery FY Final: August 15
CMHSOC Quarterly Report – *Template 20*	Guidance 31	Quarterly	October 12, January 20, April 12, and July 20
C3-4 Required Contract Forms and Documents			
Proof of Insurance	Section 4.5 and Section A-4.2	Annually; and As needed	Initial: upon execution; Annual: March 31; and As needed: Within 30 days of a modification of terms
Employment Screening Affidavit	Section 4.14.2	Annually	Later of July 1 or Anniversary of Previous Annual
Security Agreement Form	Section 5.5.3	Annually	Upon execution; Updated annually
Civil Rights Compliance Checklist - *CF Form 946*	Section 7.13 & CFOP 60-16 45 CFR, Part 80	Initial, and Annually	Initial: Within 30 days of execution, Thereafter: July 15
Emergency Preparedness Plan	Section 9.2	Initial, and Annual Update	Initial: Within 30 days of execution; Update: every 12 months after acceptance of Initial
C3-5 Functional Tasks and Deadlines			
Notification of Network Service Provider performance that may interrupt service delivery or involve media coverage	Section C-1.2.5	As needed	Within 48 hours
Incident Report Submission to IRAS- Management & Oversight	Sections 4.13 and C-1.2.8		Upon discovery of an incident
Designate CCP Providers	Section C-1.6.2.1	Once; and As needed	Initial: Within 60 days of execution; As needed: Within 10 days of any change
Staffing Changes – CEO, COO, CFO	Section C-2.1.2	As needed	Within 5 business days of any change
Staff Designations: • **Responsible for providing immediate response** • **Consumer Affairs Representative** • **Facility Representative** • **Network Service Provider Affairs Ombudsman** • **Data Officer** • **Lead Housing Coordinator**	Section C-2.1.4	Initial	Initial: upon execution
Establish & maintain internet-based electronic vault for access contract-related documents	Sections C-2.2.6 and C-2.4.2	Once; and As needed	Initial: Within 60 days of assignment As Needed: New documents within 10 business days

EXHIBIT D – DELIVERABLES

D-1 Service Unit

D-1.1 The primary service unit is one month of the Managing Entity's performance of the functions specified in **Exhibits C, C1 and C2** and the delivery of Behavioral Health Services detailed in **Template 11 – Managing Entity Monthly Progress Report.**

D-1.2 In the event the Department authorizes Disaster Behavioral Health (DBH) Response services, as detailed in **Section C-1.6.**

D-1.2.1 A supplemental service unit is one month of subcontracted DBH services in any county identified by the Department in **Exhibit C2.**

D-1.2.2 Minimum performance for payment is one hour of actual service time documented as detailed in **Section F-8,** using **Template 24 - Disaster Behavioral Health Managing Entity Supplemental Invoice and Expenditure Report.**

D-2 General Performance Specifications

The Managing Entity shall be solely and uniquely responsible for the satisfactory performance of the tasks described in this Contract. By execution of this Contract, the Managing Entity assumes responsibility for the tasks, activities, and deliverables described herein; and warrants that it fully understands all relevant factors affecting accomplishment of the tasks, activities, and deliverables; and agrees to be fully accountable for the performance thereof whether performed by the Managing Entity or its Network Service Providers.

D-3 Performance Measures for Acceptance of Deliverables

D-3.1 To obtain approval of deliverables and services for payment,

D-3.1.1 The Managing Entity must document monthly progress toward compliance with the performance outcome targets specified in **Section E-1**, and

D-3.1.2 The Managing Entity must document the Network's monthly progress toward the annual fiscal year service output measure targets in **Section E-3.**

D-3.2 The Managing Entity is responsible and accountable for meeting all performance outcomes measure targets. The Managing Entity shall manage and oversee the collection of data from Network Service Providers in order to assure that targets are met, as a Network.

D-3.3 The performance measure targets shall be subject to periodic review by the Department and adjustments to the targets or the measures may be recommended as a part of **Template 4 – Managing Entity Annual Business Operations Plan.**

D-3.4 The Managing Entity agrees that the SAMH Data System will be the source for all data used to determine compliance with performance measures. Performance of Network Service Providers shall be monitored and tracked by the Managing Entity. The Managing Entity shall provide applicable technical assistance to Network Service Providers and initiate corrective actions, as required, and will report to the Department.

D-4 Performance Measurement Terms

PAM 155-2 provides the definitions of the data elements used for various performance measures and contains policies and procedures for submitting the required data into the SAMH Data System.

D-5 Performance Measurement Methodology

The methodology and algorithms to be used in assessing the Managing Entity's performance are outlined in **Guidance 24 – Performance Outcomes Measurement Manual.**

EXHIBIT E – MINIMUM PERFORMANCE MEASURES

E-1 To demonstrate delivery of the Service Tasks detailed in **Section C-1**, the Managing Entity shall meet the annual performance measures in **Table 3**.

Table 3 – Managing Entity Performance Measures

Measure Description	Consequence
Systemic Monitoring: The Managing Entity shall complete on-site monitoring, in accordance with **Section C-1.3** of no less than twenty percent of all Network Service Providers each fiscal year. Completion of monitoring includes the release of a final monitoring report to the Network Service Provider. Progress towards attainment of this measure shall be demonstrated by the achievement of the following quarterly milestones. Each fiscal year, the Managing Entity shall monitor a minimum of: **E-1.1** 7% of its Network Service Providers by December 31; **E-1.2** 15% of its Network Service Providers by March 31; and **E-1.3** 20% of its Network Service Providers by June 30.	Failure to meet the standard shall be considered nonperformance pursuant to **Section E-5.**
Network Service Provider Compliance: **E-1.4** For each Network Service Provider Measure established in **Table 4**, subcontracted services within the Managing Entity's service location shall collectively achieve a minimum of 95% of the annual target level for the measure. This measure shall be demonstrated on an annual basis. Progress towards attainment of this measure shall be demonstrated by the monthly submission of **Template 11 – Managing Entity Monthly Progress Report.** This measure shall be calculated as an aggregate of all applicable services reported by all subcontracted Network Service Providers taken collectively. The Managing Entity may establish subcontract targets which vary from the targets in **Table 4** for any Network Service Provider or any individual measure, so long as the aggregate performance of all Network Service Providers in the Managing Entity system attains the **Table 4** target performance.	Failure to meet the standard shall be considered nonperformance pursuant to **Section E-5.**
Block Grant Implementation: The Managing Entity shall ensure 100% of the cumulative annual Network Service Provider expenses comply with the Block Grants and maintenance of effort allocation standards established in **Section B1-2.2.** Progress towards attainment of this measure shall be demonstrated by the achievement of quarterly milestones for each fiscal year. Of the annual amount for each specified fund source appropriated to the Managing Entity, the following minimum percentages of each fund's amount shall be documented as expended in compliance with the applicable allocation standard: **E-1.5** A minimum of 50% expended by December 31; **E-1.6** A minimum of 100% by June 30.	Failure to meet the standard shall be considered nonperformance pursuant to **Section E-5** and shall require payback of deficiency by the Managing Entity.
Implementation of General Appropriations Act: The Managing Entity shall meet 100% of the following requirements, by September 30: **E-1.7** Implementation of Specific Appropriations demonstrated by contracts with Network Service Providers; and **E-1.8** Submission of all plans, pursuant to **Exhibit C3**.	Failure to meet the standard shall be considered nonperformance pursuant to **Section E-5.**

E-2 To comply with the subcontract content requirements of **Section C-2.2**, the Managing Entity shall incorporate the Network Service Provider Measures in **Table 4** into each Network Service Provider subcontract, as appropriate to the services and target populations in each subcontract. The Managing Entity is not required to apply the Network Targets to each individual subcontract. Rather, the Managing Entity shall establish specific targets for each measure in each subcontract, sufficient to ensure the Network cumulatively reaches the specified Network Targets.

Table 4 – Network Service Provider Measures

	Target Population and Measure Description	Network Target	Minimum Acceptable Network Performance
Adult Community Mental Health			
MH003	Average annual days worked for pay for adults with severe and persistent mental illness	40	38
MH703	Percent of adults with serious mental illness who are competitively employed	24%	22.8%
MH742	Percent of adults with severe and persistent mental illnesses who live in stable housing environment	90%	85.5%
MH743	Percent of adults in forensic involvement who live in stable housing environment	67%	63.7%
MH744	Percent of adults in mental health crisis who live in stable housing environment	86%	81.7%
Adult Substance Abuse			
SA753	Percentage change in clients who are employed from admission to discharge	10%	9.5%
SA754	Percent change in the number of adults arrested 30 days prior to admission versus 30 days prior to discharge	15%	14.3%
SA755	Percent of adults who successfully complete substance abuse treatment services	51%	48.5%
SA756	Percent of adults with substance abuse who live in a stable housing environment at the time of discharge	94%	89.3%
Children's Mental Health			
MH012	Percent of school days seriously emotionally disturbed (SED) children attended	86%	81.7%
MH377	Percent of children with emotional disturbances (ED) who improve their level of functioning	64%	60.8%
MH378	Percent of children with serious emotional disturbances (SED) who improve their level of functioning	65%	61.8%
MH778	Percent of children with emotional disturbance (ED) who live in a stable housing environment	95%	90.3%
MH779	Percent of children with serious emotional disturbance (SED) who live in a stable housing environment	93%	88.4%
MH780	Percent of children at risk of emotional disturbance (ED) who live in a stable housing environment	96%	91.2%
Children's Substance Abuse			
SA725	Percent of children who successfully complete substance abuse treatment services	48%	45.6%
SA751	Percent change in the number of children arrested 30 days prior to admission versus 30 days prior to discharge	20%	19.0%
SA752	Percent of children with substance abuse who live in a stable housing environment at the time of discharge	93%	88.4%

E-3 To demonstrate delivery of the Service Tasks detailed in **Section C-1**, and the subcontract content requirements of **Section C-2.3**, the Managing Entity shall ensure the Network cumulatively reaches the annual output measures in **Table 5.**

Table 5 – Network Service Provider Output Measures Persons Served for Fiscal Year		
Program	**Service Category**	**FY Target**
Adult Mental Health	Residential Care	383
	Outpatient Care	8,428
	Crisis Care	5,790
	State Hospital Discharges	72
	Peer Support Services	470
Children's Mental Health	Residential Care	5
	Outpatient Care	1,272
	Crisis Care	228
Adult Substance Abuse	Residential Care	750
	Outpatient Care	7,003
	Detoxification	1,063
	Women's Specific Services	2,080
	Injecting Drug Users	615
	Peer Support Services	375
Children's Substance Abuse	Residential Care	35
	Outpatient Care	2,113
	Detoxification	1
	Prevention	27,352

E-4 If the Managing Entity fails to perform in accordance with this Contract or fails to perform the minimum level of service required by this Contract, the Department will apply financial consequences provided for in **Section E-5**. The parties agree that the financial consequences provided for under **Section E-5** constitute financial consequences under ss. 287.058(1)(h); and 215.971(1)(c), F.S. The foregoing does not limit additional financial consequences, which may include but are not limited to refusing payment, withholding payment until deficiency is cured, tendering partial payments, applying payment adjustments for additional financial consequences to the extent that this Contract so provides, or termination pursuant to the terms of **Section 6.2**, and requisition of services from an alternate source. Any payment made in reliance on the Managing Entity's evidence of performance, which evidence is subsequently determined to be erroneous, will be immediately due as an overpayment in accordance with **Section 3.5**, to the extent of such error.

E-5 Corrective Action for Performance Deficiencies

E-5.1 By execution of this Contract, the Managing Entity hereby acknowledges and agrees that its performance under the Contract must meet the standards set forth above and will be bound by the conditions set forth in this Contract. If performance deficiencies are not resolved to the satisfaction of the Department within the prescribed time, and if no extenuating circumstances can be documented by the Managing Entity to

the Department's satisfaction, the Department may terminate the contract. The Department has the exclusive authority to determine whether there are extenuating or mitigating circumstances.

E-5.2 In accordance with the provisions of s. 402.73(1), F.S., and Rule 65-29.001, F.A.C., corrective action may be required for noncompliance, nonperformance, or unacceptable performance under this Contract. Financial consequences may be imposed for failure to implement or to make acceptable progress on such corrective action.

E-6 For reference purposes, **Table 6** identifies additional minimum performance measures identified in other documents incorporated by reference into this Contract. The Managing Entity shall include the measures in **Table 6** in subcontracts for the specified services or programs, wherever appropriate.

Table 6 – Network Service Provider Subcontracted Performance Measures

Service	Required by	Subcontracted Performance Measure	Target
Prevention Services	Guidance 10, Section B.12	Tasks and activities shall be completed as outlined in the Work Plan	80%
		Data shall be submitted no later than the 15th of every month	90%
		Department-identified errors in data submitted shall be corrected within thirty (30) days of notification	90%
Prevention Partnership Grants (PPG)	Guidance 14, Section 3	Improvements in these state priorities for consumption reductions: Underage Drinking; Marijuana Use; and Non-Medical Prescription Drug Use	As Negotiated
	Guidance 14, Section 4	Quantify the activities of a program or strategy to evaluate the extent to which a program is implemented	As Negotiated
Florida Assertive Community Treatment (FACT) Handbook	Guidance 16, Section II.I.	Stable Housing	90% or most current guidance
		Days Worked	40 days or most current guidance
		Initial Assessments	90% on day of enrollment
		Comprehensive Assessments	90% within 60 days of enrollment
		Individualized Comprehensive Recovery Plan	90% within 90 days of enrollment
		Completed psychiatric/social functioning history time line	90% within 120 days of enrollment
		Work Related Services	50%
		Housing Services	90%
		Staffing Requirements	90%
		Admissions to SMHTF	30 days of discharge
		Improved Level of Functioning	75%
Family Intensive Treatment (FIT) Model Guidelines and Requirements	Guidance 18	Monthly and Yearly Service Targets	As Negotiated
		Stable Housing	90%
		Parenting Functioning	80%

Table 6 – Network Service Provider Subcontracted Performance Measures			
Service	**Required by**	**Subcontracted Performance Measure**	**Target**
Central Receiving Systems Grant Revised	Guidance 27, Section F	Reduce Drop-Off Processing Time	As Negotiated
		Increase Participant Access to Community-based Behavioral Health Services	As Negotiated
		Reduce number of individuals Admitted to SMHTF	As Negotiated
		Two Additional Specific Measures	As Negotiated
Children's Mental Health System of Care (CMHSOC) Expansion and Sustainability Project	Guidance 31, Template 20	Number in workforce trained consistent with the goals of the grant	As Negotiated
		Number people providing Mental Health Services	As Negotiated
		Number inter-agency agreements	As Negotiated
Community Action Treatment (CAT) Team	Guidance 32, Section XV	School Attendance	80%
		Improved Level of Functioning based upon CFARS or FARS	80%
		Living in a Community Setting	90%
		Improved Family Functioning, based on Child Well-being Domain, NCFAS-G+R	65%

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EXHIBIT F – METHOD OF PAYMENT

F-1 Funding

F-1.1 This advance fixed price, fixed payment Contract is comprised of federal and state funds, subject to reconciliation. **Exhibit F1** identifies the type and amount of funding provided. At the beginning of each fiscal year, the **Exhibit F1** will be amended into this Contract, and the total Contract amount in **Table 7** will be adjusted accordingly.

F-1.2 The contract total dollar amount shall not exceed the amount specified in **Section 1.1**, subject to the availability of funds, as specified in **Table 7**.

Table 7 – Contract Funding

State Fiscal Year	Managing Entity Operational Cost	Direct Services Cost	Supplemental DBH Funds	Total Value of Contract
2012-2013	$ 1,642,303.68	$ 28,436,518.39		$ 30,078,822.07
2013-2014	$ 2,285,924.00	$ 43,857,573.00		$ 46,143,497.00
2014-2015	$ 2,304,258.26	$ 44,246,413.74		$ 46,550,672.00
2015-2016	$ 2,298,027.15	$ 48,769,242.85		$ 51,067,270.00
2016-2017	$ 2,657,237.00	$ 51,122,907.00		$ 53,780,144.00
2017-2018	$ 2,676,785.00	$ 55,137,143.00	$161,671.00	$ 57,975,599.00
2018-2019	$ 2,646,718.00	$ 60,107,395.00		$ 62,754,113.00
2019-2020	$ 2,,985,875.00	$ 63,239,058.00		$ 66,224,933.00
2020-2021	$ 2,269,791.00	$ 55,680,434.00		$ 57,950,225.00
2021-2022	$ 2,269,791.00	$ 55,680,434.00		$ 57,950,225.00
2022-2023	$ 2,269,791.00	$ 55,680,434.00		$ 57,950,225.00
2023-2024	$ 2,269,791.00	$ 55,680,434.00		$ 57,950,225.00
Total	**$ 28,576,292.09**	**$ 617,637,986.98**	**$161,671.00**	**$ 646,375,950.07**

F-2 Payment

F-2.1 The Department will pay the Managing Entity an operational cost for the management of the Network in accordance with the terms and conditions of this Contract. The direct service cost is defined as the annual value of the Contract less the total value of both the Managing Entity operational cost and the Supplemental DBH Funds.

F-2.2 In accordance with s. 394.9082, F.S., the Department will pay the Managing Entity a two-month advance at the beginning of each fiscal year. Thereafter, the Managing Entity shall request monthly fixed payments equal to the fiscal year contract balance divided by the number of months remaining in the fiscal year. The advance and payment amounts for each fiscal year are specified in **Exhibit F2.** The payment request may be subject to financial consequences, pursuant to **Section E-5.2.**

F-2.3 The Managing Entity shall temporarily invest surplus advance funds in an insured interest bearing account, in accordance with s. 216.181(16)(b), F.S. The Managing Entity shall remit to the Department, on a quarterly basis, any interest earned on advance funds via check. The Managing Entity must submit documentation from the financial entity where said funds are invested, evidencing the Annual Percentage Rate and actual interest income for each month.

F-2.4 The Managing Entity shall expend any advance in accordance with the General Appropriations Act.

F-2.5 The Managing Entity shall request payment in accordance with **Section F-3.**

F-3 Invoice Requirements

F-3.1 In accordance with **Exhibit F2**, the Managing Entity shall:

F-3.1.1 Request payment monthly through the submission of a properly completed **Template 10 – Managing Entity Monthly Fixed Payment Invoice**; and

F-3.1.2 Submit a properly completed **Template 11 – Managing Entity Monthly Progress Report,** for the month that payment is requested.

F-3.1.3 Submit a properly completed **Template 12 – Managing Entity Monthly Expenditure Report**, detailing actual costs incurred by the Managing Entity for the month that payment is requested. The SAMH Managing Entity Monthly Expenditure Report shall be certified by an authorized representative; and

F-3.1.4 Submit a properly completed **Template 13 – Managing Entity Monthly Carry Forward Expenditure Report**, detailing the expenditure of approved carry forward funds, until said funds are fully expended.

F-3.2 Failure to submit the properly completed required documentation shall cause payment to be delayed until such documentation is received. Submission and approval of the elements in **Sections F-3.1** for the invoice period shall be considered the deliverables necessary for payment.

F-3.3 Within five business days of receipt of a properly completed invoice and **Template 11 – Managing Entity Monthly Progress Report**, the Contract Manager will either approve the invoice for payment or notify the Managing Entity in writing of any deficiencies that must be corrected by the Managing Entity before resubmission of the invoice.

F-3.4 The Department and the state's Chief Financial Officer reserve the right to request supporting documentation at any time, prior to the authorization of payment.

F-4 Cost Allocation Plan

F-4.1 The Managing Entity shall submit an initial **Template 14 – Cost Allocation Plan** within 30 days of execution and a revised Cost Allocation Plan to the Contract Manager annually by August 31, unless otherwise extended in writing by the Department.

F-4.2 The Department will review the Cost Allocation Plan and provide any comments within 15 days of submission. Revisions required by the Department shall be submitted by the date of the payment request for September. Failure to have an approved Cost Allocation Plan by September 20, unless extended in writing by the Department, will result in no further payment being made to the Managing Entity until the Department approves the Cost Allocation Plan.

F-4.3 The Managing Entity shall submit a revised Cost Allocation Plan whenever the Managing Entity:

F-4.3.1 Experiences a change in the type of funding it receives, whether under this Contract or an outside funding source; for example, when a new OCA is added, when a new outside funding source contributes to the Managing Entity's operational revenue or when an existing funding source is discontinued;

F-4.3.2 Makes internal organizational changes that affect the cost allocation methodology; or

F-4.3.3 Makes any changes in the allocation of costs relative to funds provided under this Contract and other outside sources.

F-4.4 The Managing Entity may request to amend or revise their Cost Allocation Plan at any time during the state fiscal year, in writing to the Contract Manager. The Managing Entity shall submit the amended or revised Cost Allocation Plan within 20 days of providing written notification. The Department will review and

provide written comments within 15 days of submission. The Managing Entity must submit a revised Cost Allocation Plan addressing any revisions required by the Department, within 15 days of the date of the Department's written response.

F-5 Carry Forward Funding

F-5.1 In accordance with s. 394.9082, F.S., the Managing Entity may carry forward documented unexpended state funds from one fiscal year to the next fiscal year, unless the following fiscal year falls outside the contract period, subject to the following conditions.

F-5.1.1 Any funds carried forward shall be expended in accordance with the General Appropriations Act in effect when the funds were allocated to the Managing Entity

F-5.1.2 The cumulative amount carried forward may not exceed eight percent of the contract total. Any unexpended state funds in excess of eight percent must be returned to the Department.

F-5.1.3 The funds carried forward may not be used in any way that would create increased recurring future obligations, and such funds may not be used for any type of program or service that is not currently authorized by this contract.

F-5.1.4 Any unexpended funds that remain at the end of the contract period shall be returned to the Department.

F-5.2 Within 30 days after receiving confirmation of the approved carried forward amount from the Department, The Managing Entity shall submit a properly completed **Template 15 – Managing Entity Spending Plan for Carry Forward Report**.

F-6 Allowable Costs

F-6.1 All costs associated with performance of the services contemplated by this contract must be both reasonable and necessary and in compliance with the cost principles pursuant to 2 CFR Part 200 – Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards - Subpart E, 45 CFR Part 75 - Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards - Subpart E, The Reference Guide for State Expenditures, and Ch. 65E-14, F.A.C.

F-6.2 Unless otherwise specified in writing by the federal grant issuing agency, none of the funds provided under any federal grants may be used to pay the salary of an individual at a rate in excess of Level II of the Executive Schedule, published but the U.S. Office pf Personnel Management at:

https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/

F-6.3 Any compensation paid for an expenditure subsequently disallowed as a result of the Managing Entity's or any Network Service Providers' non-compliance with state or federal funding regulations shall be repaid to the Department upon discovery.

F-6.4 Invoices must be dated, signed by an authorized representative of the Managing Entity and submitted in accordance with the submission schedule in this contract, with appropriate service utilization and Individuals Served data accepted into the SAMH Data System, in accordance with PAM 155-2.

F-6.5 The Managing Entity is expressly prohibited from expending funds specified as "Direct Services Costs" in **Table 7,** for anything other than a subcontract with a Network Service Provider.

F-7 Financial Reconciliation

F-7.1 The Managing Entity shall submit reports that reflect the Managing Entity's actual operational cost and the actual service cost of the Network in accordance with **Exhibit F2**. The Managing Entity shall submit a final Managing Entity Monthly Expenditure Report annually no later than August 15. Payment for the final month of the fiscal year and carry forward shall not be approved until final reconciliation has been completed by the Department.

F-7.2 The Department will reconcile actual expenditures reported to the funds disbursed to the Managing Entity based on the properly completed Managing Entity Monthly Expenditure Reports and the Managing Entity Monthly Carry Forward Expenditure Reports, according to the following schedule:

F-7.2.1 Quarterly, after September, 30, December 31, March 31, and June 30 each state fiscal year during desk reviews; and

F-7.2.2 Annually, after June 30 each state fiscal year during year end reconciliation.

F-7.3 Any funds disbursed to the Managing Entity that are not expended or were determined to have been expended for unallowable costs shall be considered overpayment to the Managing Entity. The Department shall recoup such overpayments pursuant to **Section 3.5.** In the event an overpayment is identified after the end of a fiscal year and no further invoice is due, the Managing Entity shall remit the overpayment to the Department via check.

F-8 Supplemental Disaster Behavioral Health Provisions

Whenever the Department authorizes Disaster Behavioral Health (DBH) response services, pursuant to **Section C-1.6**, the following provisions shall apply, notwithstanding any provisions in this Contract to the contrary.

F-8.1 Supplemental Payments

F-8.1.1 The terms of **Section F-2** notwithstanding, the Department will pay the Managing Entity each month for the amount of actual expenditures incurred by the Managing Entity or its Network Service Providers in the course of providing FEMA Crisis Counseling Program (CCP) services or other authorized DBH services.

F-8.1.2 Funds designated in **Exhibit F1** for CCP or other DBH services shall be excluded from the fixed payment calculations specified in **Exhibit F2.**

F-8.2 Supplemental Allowable Costs

F-8.2.1 The terms of **Section F-6** notwithstanding, allowable costs for DBH response services is expressly limited to the extent such expenditures are allowable under the terms and conditions of any funds awarded to the Department for the purpose of responding to a specific disaster event.

F-8.2.2 In response to each event, the Notice of Award, the Department's DBH application, plan of service, and budget narratives identifying allowable costs shall be incorporated by reference into **Exhibit C2.**

F-8.3 Supplemental Invoices

F-8.3.1 The terms of **Section F-3** notwithstanding, the Managing Entity shall request payment for DBH response services through submission of **Template 24 - Disaster Behavioral Health Managing Entity Supplemental Invoice and Expenditure Report.**

F-8.3.2 The Managing Entity shall submit supplemental invoices on or before the 20th of each month for services provided during the preceding month, unless the Department approves a request for an alternative invoicing schedule in writing.

F-8.4 Supplemental Financial Reconciliations

The terms of **Section F-7** notwithstanding, the Managing Entity shall submit financial reports reflecting actual DBH service expenses of the Managing Entity and its Network Service Providers as scheduled by and using templates distributed by the Department's Disaster Behavioral Health Coordinator. Actual DBH expenses may not include any Managing Entity allocated, administrative, overhead or indirect expenses without express advance written authorization by the Department's Disaster Behavioral Health Coordinator.

Exhibit F1 - ME Schedule of Funds
Broward Behavioral Health - Contract# JH343
FY 2019-20 Use Designation - As of 7/1/2019

Other Cost Accumulators Title	Line #	GAA Category	Other Cost Accumulators (OCA)	Federal	State	Total	The Amount of Non-Recurring Funds Included in Total Amount
Managing Entity Operational Cost							
ME Administrative Cost	360	106220	MHSC0	149,418	2,120,373	2,269,791	
ME MH Block Grant Technical Assistance	373	100778	MHT25	11,000	-	11,000	11,000
ME Road to Recovery - Modernizing Behavioral Health Sys	373	100778	MS918	-	459,990	459,990	459,990
ME MH System of Care	373	100778	MH0SK	-	-	-	
ME MH System of Care - Admin - Year 4	373	100778	MH0S4	-	-	-	
ME State Opioid Response Disc Grant Admin	360	106220	MSSOA	77,585	-	77,585	77,585
ME State Opioid Response Disc Grant Admin - Year 2	360	106220	MSSA2	167,509	-	167,509	167,509
Total Operational Cost				405,512	2,580,363	2,985,875	716,084
Direct Services Cost							
Mental Health Core Services Funding							
ME Mental Health Services & Support	368/369/ 372/373	100610/100611/ 100777/100778	MH000	2,540,088	16,618,915	19,157,003	
ME Early Intervention Svs - Psychotic Disorders	368	100610	MH026	750,000	-	750,000	
ME MH State Funded Federal Excluded Services	368/369	100610/100611	MHSFP	-	3,987,608	3,987,608	
Total Mental Health Core Services Funding				3,290,088	20,604,523	23,894,611	-
Mental Health Discretionary Grants Funding							
ME FL SOC Expansion and Sustainability Project	368	100610	MHESP	-	-	-	
ME FL SOC Expansion and Sustainability Project - Year 4	368	100610	MHES4	-	-	-	
ME PATH Grant	368	100610	MH0PG	325,000	-	325,000	
ME MH FL Youth Transition to Adulthood - Year 5	368	100610	MHTA5	-	-	-	
ME MH Florida Hurricane SERG	368	100610	MHFLH	-	-	-	
Total Mental Health Discretionary Grants Funding				325,000	-	325,000	-
Mental Health Proviso Projects Funding							
ME Stewart-Marchman Behavioral Healthcare	373	100778	MH011	-	-	-	
ME MH Apalachee Center - Forensic Treatment Services	368	100610	MH012	-	-	-	
ME MH South Florida Behavioral Network-IOS Pilot Project	373	100778	MH021	-	-	-	
ME Directions for Living	373	100778	MH027	-	-	-	
ME David Lawrence Center-Behavioral Health Services	373	100778	MH031	-	-	-	
ME Baycare Behavioral Health- Veterans Intervention Program	373	100778	MH032	-	-	-	
ME Youth Crisis Center - Touchstone Village	373	100778	MH033	-	-	-	
ME UF Health Center for Psychiatry	373	100778	MH034	-	-	-	
ME Life Stream Central Receiving System- Citrus County	373	100778	MH035	-	-	-	
ME FL Recovery Schools - Youth BH Wraparound Services	373	100778	MH038	-	-	-	
ME Fort Myers Salvation Army	373	100778	MH037	-	-	-	
ME Cornerstone Florida	373	100778	MH046	-	-	-	
ME NW Behavioral Health Services - Training Trauma Now	373	100778	MH048	-	-	-	
ME Bridgeway Center - Okaloosa Telehealth Svcs	373	100778	MH049	-	-	-	
ME Okaloosa/Walton MH & SA Pretrial Diversion Project	373	100778	MH051	-	-	-	
ME Veterans Alternative Retreat Program	373	100778	MH060	-	-	-	
ME Northside Mental Health Center	373	100778	MH061	-	-	-	
ME Clay Behavioral Health Center - Crisis Prevention	373	100778	MH069	-	-	-	
ME MH Citrus Health Network	368	100610	MH084	-	-	-	
ME Jerome Golden Center	373	100778	MH099	-	-	-	
ME Grace Point Center	373	100778	MH819	-	-	-	
ME Lifestream Center	373	100778	MHS50	-	-	-	
ME Circles of Care - Crisis Stabilization	373	100778	MHS52	-	-	-	
ME Renaissance Manor	373	100778	MHRM5	-	-	-	
Total Mental Health Proviso Projects Funding				-	-	-	-
Mental Health Targeted Services Funding							
ME MH Purchase of Residential Treatment Services for Emotionally Disturbed Children and Youth	376	102780	MH071	-	150,762	150,762	
ME MH Community Forensic Beds	368	100610	MH072	-	653,466	653,466	
ME MH Florida Assertive Community Treatment (FACT) Administration	368	100610	MH073	355,875	701,059	1,056,934	
ME MH Indigent Psychiatric Medication Program	376	101350	MH076	-	74,817	74,817	
ME MH Title XXI Children's Health Insurance Program (Behavioral Health Network)	368	100610	MH0BN	544,520	24,055	568,575	
ME MH Care Coordination Direct Client Services	368	100610	MH0CN	-	354,056	354,056	
ME Community Forensic Multidisciplinary Teams	368	100610	MH0FH	-	852,000	852,000	
ME MH Temporary Assistance for Needy Families (TANF)	368	100610	MH0TB	769,532	-	769,532	
ME MH Community Action Treatment (CAT) Teams	367	100425	MHCAT	-	750,000	750,000	
ME Apalachee Center - Liberty & Franklin MH CAT	368	100610	MH952	-	-	-	
ME MH - CAT and MRT Enhancements	368	100610	MHCME	284,396	-	284,396	284,396
ME Disability Rights Florida Mental Health	368	100610	MHDRF	-	-	-	
ME MH Supported Employment Services	368	100610	MHEMP	125,000	-	125,000	125,000
ME MH Forensic Transitional Beds	368	100610	MHFMH	-	1,401,600	1,401,600	
ME MH Mobile Crisis Teams	368	100610	MHMCT	-	118,236	118,236	
ME Centralized Receiving Facilities	371	100621	MHSCR	-	4,305,021	4,305,021	
ME MH Transitional Beds for MH Institution	368	100610	MHTMH	-	-	-	
ME Transition Vouchers Mental Health	368	100610	MHTRV	-	147,933	147,933	
Total Mental Health Targeted Services Funding				2,079,323	9,333,005	11,412,328	409,396
Subtotal Mental Health				5,694,411	29,937,528	35,631,939	409,396

Substance Abuse Core Services							
ME Substance Abuse Services and Support	370/372	100618/100777	MS000	6,662,252	4,934,619	11,596,871	
ME SA HIV Services	370	100618	MS023	460,890	-	460,890	
ME SA Prevention Services	370	100618	MS025	1,843,561	-	1,843,561	
ME SA State Funded Federal Excluded Services	370	100618	MSSFP	-	2,196,194	2,196,194	
Total Core Services Funding				7,966,703	8,230,813	16,197,616	-
Substance Abuse Discretionary Grants							
ME SA Prevention Partnership Program	370	100618	MS0PP	147,256	-	147,256	
ME FL Partnership for Success - Hospital Pilot	370	100618	MS0FH	37,500	-	37,500	37,500
ME FL Partnership for Success - Hospital Pilot - Year 4	370	100618	MS0H4	112,500	-	112,500	75,000
ME FL Partnerships for Success	370	100618	MS0FS	8,750	-	8,750	8,750
ME FL Partnerships for Success - Year 4	370	100618	MS0F4	28,250	-	28,250	17,500
ME State Epidemiology **Outcomes** Workgroup Local	370	100618	MS0WL	3,900	-	3,900	3,900
ME State Epidemiology **Outcomes** Workgroup Local - Year 4	370	100618	MS0W4	11,700	-	11,700	7,800
ME State Opioid Response **Disc Grant - H**ospital Bridge	370	100618	MSSOH	1,035,648	-	1,035,648	1,035,648
ME State Opioid Response **Disc Grant-Child Welfare**	370	100618	**MSSOW**	828,518	-	828,518	828,518
ME State Opioid Response **Disc SVCS-Rec Comm** Org	370	100618	**MSRCO**	52,500	-	52,500	52,500
ME State Opioid Response **Disc - Rec Comm** Org **- Year 2**	370	100618	**MSRC2**	112,500	-	112,500	112,500
ME State Opioid **Response Disc Grant SVCS-Prevent**	370	100618	**MSSOP**	82,852	-	82,852	82,852
ME State Opioid **Response Disc Grant SVCS-Prevent - Year 2**	370	100618	**MSSP2**	155,347	-	155,347	155,347
ME State Opioid **Response SVCS-MAT**	370	100618	**MSSOR**	1,166,748	-	1,166,748	1,166,748
ME State Opioid **Response SVCS-MAT - Year 2**	370	100618	MSSM2	2,303,753	-	2,303,753	2,303,753
Total Discretionary Grants Funding				6,087,722	-	6,087,722	6,850,316
Substance Abuse Proviso Projects 2021							
ME Projects Expansion of Substance Abuse Services for Pregnant Women and their affected **families**	370	100618	**MS091**	-	1,043,188	1,043,188	
ME SA Family Intensive Treatment (FIT)	370	100618	**MS091**	400,000	400,000	800,000	
ME SA Drug **Abuse Comprehensive Coordinating Treatment** (DACCO)	370	100618	**MS095**	-	-	-	
ME Here's Help	370	100618	**MS903**	-	-	-	
ME SA St. Johns County Sheriff's Office - Detox Program	370	100618	**MS907**	-	-	-	
ME SA Memorial Healthcare-Medication Assisted Treatment Program	373	100778	**MS912**	1,000,000	-	1,000,000	1,000,000
ME St. Vincent's Healthcare-Savings Lives Project	373	100778	**MS916**	-	-	-	
ME St. Johns Epic Recovery Center - Detox/Res Bed Capac	373	100778	**MS918**	-	-	-	
ME Road to Recovery **- Opioid Response**	370	100618	**MS920**	-	258,912	258,912	258,912
ME Special Services for Jerome Golden Center	370	100618	MSDJG	-	-	-	
Total Proviso Projects Funding				1,400,000	1,702,100	3,102,100	1,258,912
Substance Abuse Targeted Services							
ME SA Care Coordination Direct Client Services	370	100618	**MS0CN**	75,869	75,869	151,738	
ME SA Temporary Assistance for Needy Families (TANF)	370	100618	**MS0TB**	543,371	-	543,371	
ME SA Community Based Services	370	100618	**MSCBS**	-	1,426,616	1,426,616	
ME Transition Vouchers Substance Abuse	370	100618	MSTRV	-	98,056	98,056	
Total Targeted Services Funding				619,240	1,600,541	2,219,781	-
Subtotal Substance Abuse				16,073,665	11,533,454	27,607,119	7,149,228
Total All Fund Sources				22,173,588	44,051,346	66,224,933	8,274,706

Supplemental Disaster Behavioral Health (DBH) Response Funds							
ME Hurricane Michael Regular Services	373	100778	**MHHMR**	-	-	-	
ME MH Hurricane Michael Mental Health Response	366	100610	MHMMR	-	-	-	
Total DBH Response Funds				-	-	-	-

Total FY Contract Amount				**22,173,588**	**44,051,346**	**66,224,933**	**8,274,706**

EXHIBIT F2 – SCHEDULE OF PAYMENTS

F2-1 Table 7 specifies the schedule of payments for the current fiscal year of this Contract.

Table 7 - Schedule of Payments for Fiscal Year 2019-20						
Month of Services	**FY Contract Balance Prior to Payment**	**Fixed Payment Amount**	**Invoice Packet Due Date**	**Progress and Expenditure Report Period**	**Funding Amendments**	**Notes**
Annual Advance	$58,327,326.00	$9,721,221.00	7/1/19	N/A		
Jul-19	$48,606,105.00	$4,050,508.75	8/20/19	July		
Aug-19	$44,555,596.25	$4,050,508.75	9/20/19	August		
Sep-19	$48,402,694.50	$4,840,269.45	10/20/19	September	$7,897,607.00	Amendment 0038
Oct-19	$43,562,425.05	$4,840,269.45	11/20/19	October		
Nov-19	$38,722,155.60	$4,840,269.45	12/20/19	November		
Dec-19	$33,881,886.15	$4,840,269.45	1/20/20	December		
Jan-20	$29,041,616.70	$4,840,269.45	2/20/20	January		
Feb-20	$24,201,347.25	$4,840,269.45	3/20/20	February		
Mar-20	$19,361,077.80	$4,840,269.45	4/20/20	March		
Apr-20	$14,520,808.35	$4,840,269.45	5/20/20	April		
May-20	$9,680,538.90	$4,840,269.45	6/20/20	May		
Jun-20	$4,840,269.45	$4,840,269.45	8/15/20	June		
Total FY Payments		**$66,224,933.00**				
Supplemental Disaster Behavioral Health Funding		**$0.00**				
Total Contract Funding		**$66,224,933.00**				

F2-2 **Table 8** details the schedule of payments for the next Fiscal Year of this Contract.

	Table 8 - Schedule of Payments for Fiscal Year 2020-21					
Month of Services	**FY Contract Balance Prior to Payment**	**Fixed Payment Amount**	**Invoice Packet Due Date**	**Progress and Expenditure Report Period**	**Funding Amendments**	**Notes**
Annual Advance	$57,950,225.00	$9,658,370.83	7/1/20	N/A		
Jul-20	$48,291,854.17	$4,024,321.18	8/20/20	July		
Aug-20	$44,267,532.99	$4,024,321.18	9/20/20	August		
Sep-20	$40,243,211.81	$4,024,321.18	10/20/20	September		
Oct-20	$36,218,890.63	$4,024,321.18	11/20/20	October		
Nov-20	$32,194,569.45	$4,024,321.18	12/20/20	November		
Dec-20	$28,170,248.27	$4,024,321.18	1/20/21	December		
Jan-21	$24,145,927.09	$4,024,321.18	2/20/21	January		
Feb-21	$20,121,605.91	$4,024,321.18	3/20/21	February		
Mar-21	$16,097,284.73	$4,024,321.18	4/20/21	March		
Apr-21	$12,072,963.55	$4,024,321.18	5/20/21	April		
May-21	$8,048,642.37	$4,024,321.18	6/20/21	May		
Jun-21	$4,024,321.19	$4,024,321.19	8/15/21	June		
Total FY Payments		**$57,950,225.00**				

F2-3 The Department shall amend into this Contract additional Schedules of Payments for any remaining fiscal years annually following the expiration of **Table 8.**

ATTACHMENT 1

The administration of resources awarded by the Department of Children & Families to the provider may be subject to audits as described in this attachment.

MONITORING

In addition to reviews of audits conducted in accordance with 2 Code of Federal Regulations (CFR) §§ 200.500-200.521 and § 215.97, F.S., as revised, the Department may monitor or conduct oversight reviews to evaluate compliance with contract, management and programmatic requirements. Such monitoring or other oversight procedures may include, but not be limited to, on-site visits by Department staff, agreed-upon procedures engagements as described in 2 CFR § 200.425 or other procedures. By entering into this agreement, the recipient agrees to comply and cooperate with any monitoring procedures deemed appropriate by the Department. In the event the Department determines that a limited scope audit of the recipient is appropriate, the recipient agrees to comply with any additional instructions provided by the Department regarding such audit. The recipient further agrees to comply and cooperate with any inspections, reviews, investigations, or audits deemed necessary by the Department's inspector general, the state's Chief Financial Officer or the Auditor General.

AUDITS

PART I: FEDERAL REQUIREMENTS

This part is applicable if the recipient is a State or local government or a non-profit organization as defined in 2 CFR §§ 200.500-200.521.

In the event the recipient expends $750,000 or more in Federal awards during its fiscal year, the recipient must have a single or program-specific audit conducted in accordance with the provisions of 2 CFR §§ 200.500-200.521. The recipient agrees to provide a copy of the single audit to the Department's Single Audit Unit and its contract manager. In the event the recipient expends less than $750,000 in Federal awards during its fiscal year, the recipient agrees to provide certification to the Department's Single Audit Unit and its contract manager that a single audit was not required. In determining the Federal awards expended during its fiscal year, the recipient shall consider all sources of Federal awards, including Federal resources received from the Department of Children & Families, Federal government (direct), other state agencies, and other non-state entities. The determination of amounts of Federal awards expended should be in accordance with guidelines established by 2 CFR §§ 200.500-200.521. An audit of the recipient conducted by the Auditor General in accordance with the provisions of 2 CFR Part 200 §§ 200.500-200.521 will meet the requirements of this part. In connection with the above audit requirements, the recipient shall fulfill the requirements relative to auditee responsibilities as provided in 2 CFR § 200.508.

The schedule of expenditures should disclose the expenditures by contract number for each contract with the Department in effect during the audit period. The financial statements should disclose whether or not the matching requirement was met for each applicable contract. All questioned costs and liabilities due the Department shall be fully disclosed in the audit report package with reference to the specific contract number.

PART II: STATE REQUIREMENTS

This part is applicable if the recipient is a nonstate entity as defined by Section 215.97(2), Florida Statutes.

In the event the recipient expends $500,000 or more ($750,000 or more for fiscal years beginning on or after July 1, 2016) in state financial assistance during its fiscal year, the recipient must have a State single or project-specific audit conducted in accordance with Section 215.97, Florida Statutes; applicable rules of the Department of Financial Services; and Chapters 10.550 (local governmental entities) or 10.650 (nonprofit and for-profit organizations), Rules of the Auditor General. The recipient agrees to provide a copy of the single audit to the Department's Single Audit

Unit and its contract manager. In the event the recipient expends less than $500,000 (less than $750,000 for fiscal years beginning on or after July 1, 2016) in State financial assistance during its fiscal year, the recipient agrees to provide certification to the Department's Single Audit Unit and its contract manager that a single audit was not required. In determining the state financial assistance expended during its fiscal year, the recipient shall consider all sources of state financial assistance, including state financial assistance received from the Department of Children & Families, other state agencies, and other nonstate entities. State financial assistance does not include Federal direct or pass-through awards and resources received by a nonstate entity for Federal program matching requirements.

In connection with the audit requirements addressed in the preceding paragraph, the recipient shall ensure that the audit complies with the requirements of Section 215.97(8), Florida Statutes. This includes submission of a financial reporting package as defined by Section 215.97(2), Florida Statutes, and Chapters 10.550 or 10.650, Rules of the Auditor General.

The schedule of expenditures should disclose the expenditures by contract number for each contract with the Department in effect during the audit period. The financial statements should disclose whether or not the matching requirement was met for each applicable contract. All questioned costs and liabilities due the Department shall be fully disclosed in the audit report package with reference to the specific contract number.

PART III: REPORT SUBMISSION

Any reports, management letters, or other information required to be submitted to the Department pursuant to this agreement shall be submitted within 180 days after the end of the provider's fiscal year or within 30 (federal) or 45 (State) days of the recipient's receipt of the audit report, whichever occurs first, directly to each of the following unless otherwise required by Florida Statutes:

A. Contract manager for this contract (1 copy)

B. Department of Children & Families (1 electronic copy and management letter, if issued)

Office of the Inspector General
Single Audit Unit
Building 5, Room 237
1317 Winewood Boulevard
Tallahassee, FL 32399-0700

Email address: HQW.IG.Single.Audit@myflfamilies.com

C. Reporting packages for audits conducted in accordance with 2 CFR Part 200 §§ 200.500-200.521, and required by Part I of this agreement shall be submitted, when required by § 200.512 (d) by or on behalf of the recipient directly to the Federal Audit Clearinghouse using the Federal Audit Clearinghouse's Internet Data Entry System at:

https://harvester.census.gov/facweb/

and other Federal agencies and pass-through entities in accordance with 2 CFR § 200.512.

D. Copies of reporting packages required by Part II of this agreement shall be submitted by or on behalf of the recipient directly to the following address:

Auditor General
Local Government Audits/342
Claude Pepper Building, Room 401
111 West Madison Street
Tallahassee, Florida 32399-1450

Email address: flaudgen_localgovt@aud.state.fl.us

Providers, when submitting audit report packages to the Department for audits done in accordance with 2 CFR §§ 200.500-200.521, or Chapters 10.550 (local governmental entities) or 10.650 (nonprofit or for-profit organizations), Rules of the Auditor General, should include, when available, correspondence from the auditor indicating the date the audit report package was delivered to them. When such correspondence is not available, the date that the audit report package was delivered by the auditor to the provider must be indicated in correspondence submitted to the Department in accordance with Chapter 10.558(3) or Chapter 10.657(2), Rules of the Auditor General.

PART IV: RECORD RETENTION

The recipient shall retain sufficient records demonstrating its compliance with the terms of this agreement for a period of six years from the date the audit report is issued and shall allow the Department or its designee, Chief Financial Officer or Auditor General access to such records upon request. The recipient shall ensure that audit working papers are made available to the Department or its designee, Chief Financial Officer or Auditor General upon request for a period of three years from the date the audit report is issued, unless extended in writing by the Department.

ATTACHMENT 2

This Attachment contains the terms and conditions governing the Provider's access to and use of Protected Health Information and provides the permissible uses and disclosures of protected health information by the Provider, also called "Business Associate."

Section 1. Definitions

1.1 Catch-all definitions:

The following terms used in this Attachment shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

1.2 Specific definitions:

1.2.1 "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR § 160.103, and for purposes of this Attachment shall specifically refer to the Provider.

1.2.2 "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR § 160.103, and for purposes of this Attachment shall refer to the Department.

1.2.3. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

1.2.4. "Subcontractor" shall generally have the same meaning as the term "subcontractor" at 45 CFR § 160.103 and is defined as an individual to whom a business associate delegates a function , activity, service , other than in the capacity of a member of the workforce of such business associate.

Section 2. Obligations and Activities of Business Associate

2.1 Business Associate agrees to:

2.1.1 Not use or disclose protected health information other than as permitted or required by this Attachment or as required by law;

2.1.2 Use appropriate administrative safeguards as set forth at 45 CFR § 164.308, physical safeguards as set forth at 45 CFR § 164.310, and technical safeguards as set forth at 45 CFR § 164.312; including, policies and procedures regarding the protection of PHI and/or ePHI set forth at 45 CFR § 164.316 and the provisions of training on such policies and procedures to applicable employees, independent contractors, and volunteers, that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI and/or ePHI that the Provider creates, receives, maintains or transmits on behalf of the Department;

2.1.3 Acknowledge that (a) the foregoing safeguards, policies and procedures requirements shall apply to the Business Associate in the same manner that such requirements apply to the Department, and (b) the Business Associate's and their Subcontractors are directly liable under the civil and criminal

enforcement provisions set forth at Section 13404 of the HITECH Act and section 45 CFR §§ 164.500 and 164.502(E) of the Privacy Rule (42 U.S.C. 1320d-5 and 1320d-6), as amended, for failure to comply with the safeguards, policies and procedures requirements and any guidance issued by the Secretary of Health and Human Services with respect to such requirements;

2.1.4 Report to covered entity any use or disclosure of protected health information not provided for by this Attachment of which it becomes aware, including breaches of unsecured protected health information as required at 45 CFR § 164.410, and any security incident of which it becomes aware;

2.1.5 Notify the Department's Security Officer, Privacy Officer and the Contract Manager as soon as possible, but no later than five (5) business days following the determination of any breach or potential breach of personal and confidential departmental data;

2.1.6 Notify the Privacy Officer and Contract Manager within (24) hours of notification by the US Department of Health and Human Services of any investigations, compliance reviews or inquiries by the US Department of Health and Human Services concerning violations of HIPAA (Privacy, Security Breach).

2.1.7 Provide any additional information requested by the Department for purposes of investigating and responding to a breach;

2.1.8 Provide at Business Associate's own cost notice to affected parties no later than 45 days following the determination of any potential breach of personal or confidential departmental data as provided in section 501.171, F.S.;

2.1.9 Implement at Business Associate's own cost measures deemed appropriate by the Department to avoid or mitigate potential injury to any person due to a breach or potential breach of personal and confidential departmental data;

2.1.10 Take immediate steps to limit or avoid the recurrence of any security breach and take any other action pertaining to such unauthorized access or disclosure required by applicable federal and state laws and regulations regardless of any actions taken by the Department ;

2.1.11 In accordance with 45 CFR §§ 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the business associate agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information. Business Associate's must attain satisfactory assurance in the form of a written contract or other written agreement with their business associate's or subcontractor's that meets the applicable requirements of 164.504(e)(2) that the Business Associate or Subcontractor will appropriately safeguard the information. For prior contracts or other arrangements, the provider shall provide written certification that its implementation complies with the terms of 45 CFR § 164.532(d);

2.1.12 Make available protected health information in a designated record set to covered entity as necessary to satisfy covered entity's obligations under 45 CFR § 164.524;

2.1.13 Make any amendment(s) to protected health information in a designated record set as directed or agreed to by the covered entity pursuant to 45 CFR § 164.526, or take other measures as necessary to satisfy covered entity's obligations under 45 CFR § 164.526;

2.1.14 Maintain and make available the information required to provide an accounting of disclosures to the covered entity as necessary to satisfy covered entity's obligations under 45 CFR § 164.528;

2.1.15 To the extent the business associate is to carry out one or more of covered entity's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the covered entity in the performance of such obligation(s); and

2.1.16 Make its internal practices, books, and records available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance with the HIPAA Rules.

Section 3. Permitted Uses and Disclosures by Business Associate

3.1 The Business associate may only use or disclose protected health information covered under this Attachment as listed below:

3.1.1 The Business Associate may use and disclose the Department's PHI and/or ePHI received or created by Business Associate (or its agents and subcontractors) in performing its obligations pursuant to this Attachment.

3.1.2 The Business Associate may use the Department's PHI and/or ePHI received or created by Business Associate (or its agents and subcontractors) for archival purposes.

3.1.3 The Business Associate may use PHI and/or ePHI created or received in its capacity as a Business Associate of the Department for the proper management and administration of the Business Associate, if such use is necessary (a) for the proper management and administration of Business Associate or (b) to carry out the legal responsibilities of Business Associate.

3.1.4 The Business Associate may disclose PHI and/or ePHI created or received in its capacity as a Business Associate of the Department for the proper management and administration of the Business Associate if (a) the disclosure is required by law or (b) the Business Associate (1) obtains reasonable assurances from the person to whom the PHI and/or ePHI is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person and (2) the person agrees to notify the Business Associate of any instances of which it becomes aware in which the confidentiality and security of the PHI and/or ePHI has been breached.

3.1.5 The Business Associate may aggregate the PHI and/or ePHI created or received pursuant this Attachment with the PHI and/or ePHI of other covered entities that Business Associate has in its possession through its capacity as a Business Associate of such covered entities for the purpose of providing the Department of Children and Families with data analyses relating to the health care operations of the Department (as defined in 45 C.F.R. § 164.501).

3.1.6 The Business Associate may de-identify any and all PHI and/or ePHI received or created pursuant to this Attachment, provided that the de-identification process conforms to the requirements of 45 CFR § 164.514(b).

3.1.7 Follow guidance in the HIPAA Rule regarding marketing, fundraising and research located at Sections 45 CFR § 164.501, 45 CFR § 164.508 and 45 CFR § 164.514.

Section 4. Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions

4.1 Covered entity shall notify business associate of any limitation(s) in the notice of privacy practices of covered entity under 45 CFR § 164.520, to the extent that such limitation may affect business associate's use or disclosure of protected health information.

4.2 Covered entity shall notify business associate of any changes in, or revocation of, the permission by an individual to use or disclose his or her protected health information, to the extent that such changes may affect business associate's use or disclosure of protected health information.

4.3 Covered entity shall notify business associate of any restriction on the use or disclosure of protected health information that covered entity has agreed to or is required to abide by under 45 CFR § 164.522, to the extent that such restriction may affect business associate's use or disclosure of protected health information.

Section 5. Termination

5.1 Termination for Cause

5.1.1 Upon the Department's knowledge of a material breach by the Business Associate, the Department shall either:

5.1.1.1 Provide an opportunity for the Business Associate to cure the breach or end the violation and terminate the Agreement or discontinue access to PHI if the Business Associate does not cure the breach or end the violation within the time specified by the Department of Children and Families;

5.1.1.2 Immediately terminate this Agreement or discontinue access to PHI if the Business Associate has breached a material term of this Attachment and does not end the violation; or

5.1.1.3 If neither termination nor cure is feasible, the Department shall report the violation to the Secretary of the Department of Health and Human Services.

5.2 Obligations of Business Associate Upon Termination

5.2.1 Upon termination of this Attachment for any reason, business associate, with respect to protected health information received from covered entity, or created, maintained, or received by business associate on behalf of covered entity, shall:

5.2.1.1 Retain only that protected health information which is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities;

5.2.1.2 Return to covered entity, or other entity as specified by the Department or, if permission is granted by the Department, destroy the remaining protected health information that the Business Associate still maintains in any form;

5.2.1.3 Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health

information to prevent use or disclosure of the protected health information, other than as provided for in this Section, for as long as Business Associate retains the protected health information;

5.2.1.4 Not use or disclose the protected health information retained by Business Associate other than for the purposes for which such protected health information was retained and subject to the same conditions set out at paragraphs 3.1.3 and 3.1.4 above under "Permitted Uses and Disclosures By Business Associate" which applied prior to termination; and

5.2.1.5 Return to covered entity, or other entity as specified by the Department or, if permission is granted by the Department, destroy the protected health information retained by business associate when it is no longer needed by business associate for its proper management and administration or to carry out its legal responsibilities.

5.2.1.6 The obligations of business associate under this Section shall survive the termination of this Attachment.

Section 6. Miscellaneous

6.1 A regulatory reference in this Attachment to a section in the HIPAA Rules means the section as in effect or as amended.

6.2 The Parties agree to take such action as is necessary to amend this Attachment from time to time as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law.

6.3 Any ambiguity in this Attachment shall be interpreted to permit compliance with the HIPAA Rules.

Attachment 3

CERTIFICATION REGARDING LOBBYING

CERTIFICATION FOR CONTRACTS, GRANTS, LOANS AND COOPERATIVE AGREEMENTS

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or an employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with this federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Signature: Nan Rich Date: 8-15-2019

Application or Contract ID Number: JH343

Name of Authorized Individual Application or Contractor: Broward Behavioral Health Coalition

Address of Organization: 3521 West Broward Blvd, Suite 206
Lauderhill, Florida 33312

Broward Behavioral Health Coalition, Inc.

EXHIBIT "G"
CORe Grant Guidance

Guidance # 41
Coordinated Opioid Recovery (CORE) Network of Addiction Care

Contract Reference: *Contract Exhibit A. Administration C-1.23*

Authority: *Section 394.9082, F.S. C-1.2.3.25*

Frequency: Data submission every other week

I. Purpose

This document provides direction and guidance for administration, implementation, and management of Florida's Coordinated Opioid Recovery (CORE) Network of Addiction Care. This document outlines the purpose, policy, and competencies intended to ensure that funds are used effectively to combat opioid use disorder in Florida, in accordance with state and federal laws and regulations.

To ensure the implementation and administration of this project, the Managing Entity shall require that Network Service Providers, Emergency Medical Providers, and Emergency Departments participating in a CORE project to continue with service delivery and reporting as previously required during FY 22/23.

The Managing Entity shall not make any changes or variations from fidelity to the structure, implementation, and data collection of the CORE model as stated in this document.

II. Program Requirements

1. Provide a 24/7 access point where an individual can access medication assisted treatment (MAT), including weekends.
2. Ensure a clinic provider is available to receive individuals in need of services from the 24/7 access point, and that first responders can provide MAT until the individual can be seen in the clinic.
3. Provide treatment for co-morbid alcohol and benzodiazepine use disorders.
4. Ensure individuals receiving services have access to higher levels of care if needed, including outpatient detox.
5. Ensure the availability of clinical experts in addiction medicine, including licensed therapists in outpatient services and access to primary care for all individuals served.
6. Perform necessary lab work on all individuals to identify any infectious diseases.
7. Ensure individuals served have access to psychiatric care at the providers clinic or in the community.
8. Ensure availability of peer support staff to assist in navigating the CORE network and other supportive services needed.
9. Ensure care coordination is available based on an individual's need.
10. Ensure access to a variety of MAT, including buprenorphine (Buprenorphine) and Vivitrol, and referrals for methadone, if appropriate.
11. Capacity to continue prescribing MAT as long as the prescriber determines the medication is clinically beneficial, without any arbitrary limits on length of care.
12. Approach to dosing MAT that considers the specific circumstances and use pattern of the individual.
13. Availability to test biological specimens (e.g., urine, blood, hair) for fentanyl at the 24/7 access point and the receiving clinic.

14. Network Service Providers, Emergency Medical Providers, and Hospital Emergency Departments shall use the established clinic intake process.
15. Network Service Providers, Emergency Medical Providers, and Hospital Emergency Departments shall use the established protocol for induction on buprenorphine.
16. Naloxone kits shall be available to individuals without specific conditional requirements.
17. Provide access to group and individual therapy and recovery support groups facilitated by recovery peer specialists, where appropriate.
18. Procedures to address phases of treatment.
19. Ability to provide care to pregnant and parenting women.
20. Consistent monitoring of outcome measures and data including the use of the Brief Addiction Monitoring (BAM) tool and reporting as outlined in Section VIII of this document.

III. Eligibility

The CORE model prioritizes adults aged 18 or older who experience any of the following:

1. A confirmed or suspected opioid overdose requiring naloxone administration.
2. Signs and symptoms of severe opioid withdrawal.
3. Acute opioid withdrawal as a chief complaint.
4. Individuals seeking support for opioid use disorder (OUD) at any county CORE partner location.

IV. CORE Program Model

The CORE model establishes a recovery-oriented continuum of care and support for those seeking treatment and recovery support services for OUD. This comprehensive approach expands every aspect of overdose response and treats all primary and secondary impacts of substance use disorder (SUD). The CORE model disrupts the revolving door of addiction and overdose by providing primary care and peer navigators within the emergency department and immediately connecting individuals to sustainable overall health care. Department approval is required before implementing any variation of the CORE model.

The model includes the following tiered approach:

1. Rescue Response
2. Stabilization/ Assessment
3. Long-term Treatment
4. Recovery Supports

V. CORE Sustainability

Sustaining CORE projects in all counties will require blending and braiding from various funding sources at different levels. All participating counties will be required to submit a CORE Sustainability Plan.

VI. Managing Entity Responsibilities

To ensure consistent statewide implementation and administration of CORE, the Managing Entity shall ensure all program requirements as outlined in section II, are met through subcontracts with Network Service Providers. The Managing Entity shall implement the CORE program model in accordance with the outlined programmatic standards and in accordance with Florida's Opioid Abatement requirements. The Managing Entity shall expend the funds on approved purposes only. The Statewide Council on Opioid Abatement may pass additional measures and requirements that the Department and Managing Entities must follow when evaluating compliance, performance, and implementation. The CORE model program standards are as follows:

1. Rescue Response

- **a.** Individual in need of services is treated by first responders (fire rescue/ Emergency Medical Services (EMS) personnel).
- **b.** Treatment includes use of specialized EMS protocols for overdose and acute withdrawal.

2. Stabilization/Assessment

- **a.** Individual receives treatment in an emergency department (ED) with an addiction stabilization center.
- **b.** Treatment options include medication-assisted treatment, which entails, at a minimum, the ability to induct individuals on buprenorphine and issue a prescription for buprenorphine that lasts until their initial appointment with a community-based provider prior to being released from the ED.
- **c.** Individual is assessed and treated for emergent unmet health needs.
- **d.** Specialty-trained medical staff recommend the care best suited for the individual and a peer navigator facilitates a warm hand off to the long-term treatment provider.

3. Long-Term Treatment

- **a.** Individual receives long-term-care and wrap around support.
- **b.** Individual is treated by a team of licensed and certified professionals that specialize in treating addiction.
- **c.** Services may include long-term management of medication-assisted treatment, therapy, psychiatric services, individualized care coordination, pharmacy services, and links to other health services.
- **d.** Individuals shall receive services to address any identified social service needs.

4. Recovery Support

- **a.** Certified Recovery Peer Specialists utilize direct lived experience with SUD and recovery to reduce stigma and increase engagement into services.
- **b.** Certified Recovery Peer Specialists facilitate warm hand-offs to treatment and recovery community organizations.

5. Training

- **a.** Ensure clinical and systems training are provided to counties to promote use of evidence-based delivery of each component. Training topics should be developed based on need in counties.

Effective no later than October 1, 2023, Managing Entities in areas with an existing CORE program shall execute contracts or purchase orders with the pre-existing contracted partners for the implementation of the CORE Network of Addiction Care.

The Department will identify the next 17 counties to establish a CORE program for implementation in FY 23/24.

VII. Network Service Provider and System Partner Responsibilities

Network Service Providers, Emergency Departments, and Emergency Medical Services shall identify staff to be responsible for activities required through the CORE partnership. Network Service Providers and system partners including EDs and EMS shall implement a system of care, known as CORE, and shall provide eligible individuals with treatment that includes use of specialized protocols for overdose and acute withdrawal and provide MAT. CORE partners shall work together identifying a point of contact, preferably the peer specialist, to provide warm hand-offs as the individual transitions to different services.

Network Service Providers and system partners including EDs and EMS shall complete online CORE training available on the CORE website and any other training required by the Department.

1. **Emergency Medical Service** - Emergency Medical Service partners shall:
   - **a.** Implement use of the EMS Pre-Hospital Buprenorphine-Naloxone Induction for Opioid Use Disorder.
   - **b.** Hire and train staff on using appropriate equipment, medication, and protocols.
2. **Emergency Department-** Emergency Departments shall:
   - **a.** Implement use of specialized protocols for overdose and acute withdrawal and provide medication assisted treatment.
3. **Network Service Providers/Receiving Clinics-** Network Service Providers/Receiving Clinics shall:
   - **a.** Implement CORE model services and supports to provide treatment that includes use of specialized protocols for overdose and acute withdrawal and medication assisted treatment.
   - **b.** Hire and train staff on the established protocols, medication assisted treatment and the use of the brief addiction monitoring tool (BAM) in accordance with protocols.

VIII. Data and Reporting

1. Data Collection

Opioid settlement funds will be used to implement CORE. A required component of the state's opioid settlement is to use an evidence-based data collection process to analyze the effectiveness of substance use abatement. The opioid settlement states that the State and Local Governments shall receive and report expenditures, service utilization data, demographic information, and national outcome measures in a similar fashion as required by the 42.U.S.C. s. 300x and 42 U.S.C. s. 300x-21.

- **a.** Managing Entities shall ensure that all CORE partners comply with the required data collection process.
- **b.** Data collection should be based on standardized procedures to ensure consistency and accuracy across all service providers.
- **c.** To evaluate the effectiveness of substance use abatement, the data collection process should include tracking and measuring key outcome indicators related to opioid use disorder treatment, such as retention rates, reduction in overdose incidents, and improvements in overall well-being.

2. **Data Management And Privacy**

    a. All data collected should be stored in a secure and centralized database, accessible only to authorized personnel, to facilitate accurate reporting and analysis.

    b. Regular data audits should be conducted to ensure data integrity and identify any discrepancies or errors for timely correction.

3. **Reporting Mechanism and Format**

    All CORE partners are required to continue reporting CORE data into the ClearPoint system in the established format.

4. **Data Analysis and Utilization**

    a. The Department and Managing Entity shall collaborate in analyzing the collected data to assess the impact and effectiveness of the CORE program.

    b. Data analysis should be used to identify potential areas of improvement, refine program strategies, and inform evidence-based decision-making to enhance the overall effectiveness of the CORE program.

Broward Behavioral Health Coalition, Inc.

EXHIBIT "H"
BROWARD BEHAVORIAL HEALTH COALITION (BBHC)
E-VERIFY FORM UNDER §448.095, FLORIDA STATUTES

Contractor: **CITY OF FORT LAUDERDALE**
Project: **THE COORDINATED OPIOID RECOVERY (CORE) EXPANSION PROGRAM**

1. Definitions:

"Contractor" means a person or entity that has entered or is attempting to enter into a contract with a third party under contract with a public employer, such as BBHC, to provide labor, supplies, or services to such employer or third party in exchange for salary, wages, or other remuneration.

"Contractor" includes, but is not limited to, a vendor or consultant.

"Subcontractor" means a person or entity that provides labor, supplies, or services to or for a Contractor or another subcontractor in exchange for salary, wages, or other remuneration.

"E-Verify system" means an Internet-based system operated by the United States Department of Homeland Security that allows participating employers to electronically verify the employment eligibility of newly hired employees.

2. Effective January 1, 2021, Contractors, shall register with and use the E-verify system in order to verify the work authorization status of all newly hired employees. Contractor shall register for and utilize the U.S. Department of Homeland Security's E-Verify System to verify the employment eligibility of:

a) All persons employed by a Contractor to perform employment duties within Florida during the term of the contract; and

b) All persons (including sub vendors/subconsultants/subcontractors) assigned by Contractor to perform work pursuant to the contract with BBHC. The Contractor acknowledges and agrees that registration and use of the U.S. Department of Homeland Security's E-Verify System during the term of the contract is a condition of the contract with BBHC; and

c) Should vendor become the successful Contractor awarded for the above-named project, by entering into the contract, the Contractor shall comply with the provisions of §448.095, Florida Statutes, "Employment Eligibility," as amended from time to time. This includes but is not limited to registration and utilization of the E-Verify System to verify the work authorization status of all newly hired employees. Contractor shall also require all subcontractors to provide an affidavit attesting that the subcontractor does not employ, contract with, or subcontract with, an unauthorized alien. The Contractor shall maintain a copy of such affidavit for the duration of the contract.

3. Contract Termination

a) If BBHC has a good faith belief that a person or entity with which it is contracting has knowingly violated §448.09 (1), Florida Statute, the contract shall be terminated.

b) If BBHC has a good faith belief that a subcontractor knowingly violated §448.095 (2), but the Contractor otherwise complied with §448.095 (2), Florida Statute, shall promptly notify the Contractor and order the Contractor to immediately terminate the contract with the subcontractor.

c) A contract terminated under subparagraph a) or b) is not a breach of contract and may not be considered as such.

d) Any challenge to termination under this provision must be filed in the Circuit Court no later than twenty (20) calendar days after the date of termination.

e) If the contract is terminated for a violation of the statute by the Contractor, the Contractor may not be awarded a contract by BBHC for a period of one (1) year after the date of termination.

Company Name:
Authorized Signature:
Print Name:
Title
Date:
Phone:

STATE OF _____)
COUNTY OF _____)

The foregoing instrument was acknowledged before me by means of □ physical presence or

□ online notarization, this_____day of_____,_____, by

_____on behalf of_____. He/she is personally known to me

or has produced _____as identification.

_____
NOTARY PUBLIC

_____
(Name of Notary Typed, Printed or Stamped)